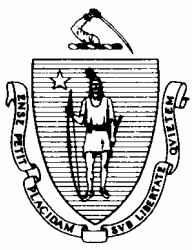

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Department of Mental Health
Department of Mental Retardation

Medication
Administration Program

MAP Policy Manual

Revised 1/1/05

Department of Public Health
Department of Mental Health
Department of Mental Retardation

Medication Administration Program
Policy Manual

January 1, 2005

The Departments of Public Health, Mental Health and Mental Retardation have compiled all existing Medication Administration Program advisories and policies into one comprehensive document, the MAP Policy Manual. The policies in this Manual, some of which are revisions of existing policies, supersede all other policies on these topics previously issued by the Departments.

The MAP Policy Manual is intended to provide service providers, trainers, staff and other interested parties with a single, topically organized source for MAP policies. Each site registered with DPH must maintain a copy of this policy manual as part of the required reference materials for MAP Certified staff.

INDEX OF SUBJECTS

01

SITE REGISTRATION

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Criteria for Site Registration with DPH **POLICY NO: 01-1**

DATE REVISED:1/1/05

Site Registration

1. MAP DPH regulations are intended to address the needs of individuals who are living in DMH/DMR licensed, funded, or operated community residential programs that are their primary residences and/or are participating in day programs and short-term respite programs caring for stable individuals. These community residential programs, day programs, and short-term respite programs may register with DPH for the purpose of authorizing non-licensed employees to administer or assist in the administration of medications (105 CMR 700.000 and 105 CMR 700.004(C)(1)(i)).

2. Those programs listed above that meet the criteria for site registration must apply for a Massachusetts Controlled Substance Registration (MCSR) from DPH. The MCSR is for the purpose of permitting medication administration by MAP Certified staff and the storage of medications on site.

3. The MCSR is issued to the geographic site where the medication is stored. For example, if there is a three family house with three staffed apartments (one on each floor) and all three apartments store medications, then all three apartments must obtain separate MCSRs. DPH issues three MCSRs, one for each apartment, not one MCSR covering the entire house. The name of the service provider will appear on all three MCSRs.

4. The original MCSR must be kept at the site with a copy of the MCSR kept at the service provider's administrative office, or vice versa.

5. Staff will need the MCSR number in order to complete a Medication Occurrence Report (MOR). This number is recorded in the section of the MOR that requests the "DPH Registration Number". In addition, the MCSR number is needed when requesting information from DPH. The MSCR number should be included in all correspondence.

6. The MCSR is valid for one year. Renewal forms must be submitted to DPH one month before the MCSR expires. The application or renewal process should take approximately four to six weeks. The previous MCSR will remain in effect until the renewal MCSR is received as long as the site has applied for renewal prior to the expiration date of the current MCSR. If you do not receive the MCSR within eight weeks, please contact DPH (see Policy 16-1).

7. The renewal MCSR applications and MCSRs are mailed to the service provider's administrative address, not the site address.

8. The MCSR issued to a site must be returned to DPH if: a) a registered site no longer houses DMH/DMR clients/consumers; b) the clients/consumers are all self-medicating; or, c) medications are no longer stored at that site. **MCSRs are not transferable.** If a site closes or changes ownership, the site is required to immediately return the MCSR to DPH with a written letter stating that the site is closed and the date of closure. If a registered site plans to relocate, the site is required to return the MCSR to DPH with a written letter stating the change of address prior to the move. The letter should include the date the new site will open and the date that the old site will close. DPH will make the necessary changes and issue an updated MCSR for the new location.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Categories of Programs Needing to Register **POLICY NO: 01-2**

POLICY SOURCE: 1994 DMR Memo **DATE ISSUED: 11/18/94**

RE: Categories of programs needing to participate in medication administration certification process.

Many questions have arisen regarding the kinds of programs responsible for certifying staff to administer medications. After consultation with our legal department, we are able to clarify this matter. Below is a response to each type of program in which questions have arisen:

1. Day programs - Any site-based day program which administers medication is required to have certified staff.

2. Personal Care Attendant arrangements in which the individual or surrogate hires the P.C.A. - The P.C.A. does not need to be certified to administer medication.

3. Specialized Home Care Providers - Under G.L.C.-112 Sec. 80B, a person employed primarily as a companion, housekeeper, domestic servant or nursemaid and is not licensed as a medical professional may administer medication. In addition, G.L.C. 94C Sec 1 indicates that a member of a household may possess controlled substances. Specialized home care providers fall within these exceptions and do not need to be certified to administer medications. However, providers are encouraged to send providers to the training for their own knowledge.

4. Respite care providers
    a) Facility-based - must be certified to administer medication.

    b) Non-facility based - does not need to be certified, under point 3. This applies to respite care providers hired by the family directly, or mediated through an agency. Agencies may set up procedures, which indicate that the family is sharing the responsibility for medication administration with the support staff much like a surrogate directs a P.C.A. to carry out such duties. Also, an agency and/or a family is encouraged to send respite providers to training.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Application for Controlled Substance Registration

POLICY NO: 01-3

DATE REVISED: 1/1/05

APPLICATIONS FOR MASSACHUSETTS CONTROLLED SUBSTANCE REGISTRATION (MCSR) FORMS MAY BE DOWNLOADED FROM THE DPH WEBSITE (see Policy 16-3 for website access information).

02

STAFF CERTIFICATION

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: MAP Certification Process & Guidelines

POLICY NO: 02-1

DATE REVISED: 12/1/03

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1. Direct care staff, including licensed nurses working in positions that do not require a nursing license, must be Certified in MAP in order to administer medications in adult DMH or DMR community programs.

2. MAP Certification is valid for use only in adult DMH and DMR community programs that possess a current and valid Massachusetts Controlled Substances Registration (MCSR) from the Department of Public Health.

3. Staff meeting certain requirements may take equivalency-based testing (see Policy 02-2, Equivalency Testing).

4. MAP Certification is effective on the date that the test results are posted on the Red Cross website indicating that the staff person passed the Certification test.

5. MAP Certification is valid for two years from the last day of the month in which the test was passed. For example, if a person passes the MAP test on 4/1/2004 and another person passes the test on 4/28/04, the expiration date in both cases is 4/30/06.

6. Once MAP Certification expires, staff have one year to recertify before they must complete the full Certification training and retake the written and skills tests. During this period of time staff may not administer medications.

7. If a Certified staff person takes a MAP Recertification test through the Red Cross, they may continue to administer medications until the results are posted on the Red Cross website. Employers are required to check the Red Cross website for test results no later than the second business day after the test. If the MAP Recertification test results show that the staff person has failed, the staff person is no longer considered to be MAP Certified and must stop administering medications immediately even if their current Certificate has not yet expired. They are not permitted to administer medications again until they retake the MAP Recertification test and it is verified on the Red Cross website that they passed.

8. If the staff person takes a MAP Recertification test through the service provider and passes, they may continue to administer medications uninterrupted. If the staff person fails, they cannot administer medications until they pass a subsequent Recertification test.

9. It is the responsibility of both the service provider and the individual who is MAP Certified to track the MAP Certification period and to assure that the MAP Certification remains current and valid.

10. Community programs are required to maintain acceptable proof of MAP Certification (see Policy 02-3). Copies of MAP Wallet Cards must be kept at either the service provider's administrative office or at the site to which the staff person is assigned. If copies of Wallet Cards are kept on-site, then a master list of all MAP Certifications dates of expiration must be maintained at the service provider's administrative office. If copies of Wallet Cards are kept at the service provider's administrative office, then a master list of all MAP Certifications with dates of expiration must be kept at each site and the sites should be prepared to provide copies of MAP Wallet Cards within 10 days of a request made by DPH, DMH or DMR.

11. Master lists may be in written, printed, electronic or any other readily retrievable format.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Equivalency Testing **POLICY NO: 02-2**

POLICY SOURCE: December 1994 Advisory **DATE ISSUED: 12/94**
Supervisor's Training Manual **DATE ISSUED: 5/15/98**
DATE REVISED: 8/1/00

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1. The following individuals may apply for equivalency-based testing, consisting of a written test and skill test, in lieu of attending the training:

   a) Licensed staff with a current license.

   b) Staff with current medication certification from another state (however, note that there is no reciprocity between states).

2. An application for equivalency testing along with one copy of the most current MAP Training Manual will be sent by the MAP Coordinator to the individual upon request.

3. The application [see policy no. 02-5, Staff Certification Forms] should be completed and signed by the individual requesting testing and mailed to the official test administrator (currently, the American Red Cross).

4. If the applicant fails either the written test or the skill test, he or she must take the full certification-training course before testing again (which is considered their second try).

5. Upon successfully passing the equivalency-based examination, an individual will be certified to administer medications in either DMH or DMR adult community programs.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Acceptable Proof of MAP Certification for Staff

POLICY NO: 02-3

DATE REVISED: 1/1/05

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1. Only the following three forms are acceptable proof of Certification to administer medications:

   a) A copy of the MAP Wallet Card issued to each MAP Certified staff person.

   b) A copy of the printout from the Red Cross website confirming that the staff person has passed the MAP Certification test. This can be found on the Red Cross Central MAP Registry Database (see Policy 16-1 for website address). A copy of the MAP Wallet Card must replace this printout as soon as it is received.

   c) A signed copy of a successfully completed *MAP Recertification Competency Evaluation Form*. A copy of the MAP Wallet Card must replace this form as soon as it is received.

2. An individual's MAP Certification status may be verified at any time by checking the Red Cross Central MAP Registry Database (see policy 16-1 for website address).

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Revocation of Certification **POLICY NO: 02-4**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 04/97**
DATE REVISED: 8/1/00

An individual's certification may be revoked in accordance with regulations of the Department of Mental Health at 104 CMR 15.03(6)(h)(4) and the Department of Mental Retardation at 115 CMR 6.06(6)(a). A certification may be revoked by the Departments, after an informal hearing, if the certified staff:

1. Has been convicted of a crime involving controlled substances;
2. Has furnished or made to the Departments any misleading or false statement in the application for or renewal of certification;
3. Has failed to exercise proper regard for the health, safety and welfare of the program clients/consumers; or
4. Is unfit to perform the duties for which the certification was granted.

The service provider shall be responsible for notification of their MAP regional/area coordinator(s) regarding any actions involving employees in these areas.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: MAP Testing Application **POLICY NO: 02-5**

DATE REVISED: 1/1/05

APPLICATIONS FOR MAP TESTING MAY BE DOWNLOADED FROM THE AMERICAN RED CROSS WEBSITE (see Policy 16-1 for website access information).

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: MAP Pre-testing **POLICY NO: 02-6**

DATE ISSUED: 9/30/03

Upon completion of the MAP Certification Training, an individual is required to pass a written Standardized Pretest issued by the American Red Cross (ARC) before they can apply to take the MAP Certification exam.

1. Staff must complete a MAP Certification course taught by an Approved MAP Trainer.

2. Upon completion of the Certification course, an Approved MAP Trainer or a Designated Test Administrator will administer the written Standardized Pretest. A Designated Test Administrator is an individual who has been authorized to administer the Standardized Pretest by an Approved MAP Trainer.

3. If the staff person passes the Standardized Pretest by answering 24 or more questions correctly (6 or less incorrectly) they may then be scheduled to take the ARC MAP Certification exam.

4. If the staff person does not pass the Standardized Pretest according to the criteria in #3 above, they must take the Pretest again until they pass. Additional training may be provided if that is available to the staff person.

5. Pretest Answer Sheets are to be maintained by the Provider and be available for review by the DMH Area or DMR Regional MAP Coordinator upon request.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Testing: Certification and Recertification **POLICY NO: 02-7**

DATE REVISED: 12/1/03

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1. The American Red Cross (ARC) conducts all initial MAP Certification testing.

2. The MAP Recertification process may be completed in one of two ways:

   a) By the ARC Recertification testing by ARC will include demonstrated competence in medication administration via use of a standardized skills test. *See Policy 02-5 for instructions on obtaining the application forms*.

   b) By an Approved MAP Trainer at an actual program site or as a "role play" at a site designated by the Provider Agency. An Approved MAP Trainer, using the attached *MAP Recertification Competency Evaluation Form*, must complete a skills evaluation and forward the results to an agency-designated supervisory staff person for review and signature. Please refer to attached *MAP Recertification Evaluator's Manual* for further details on specific processes and procedures.

3. Staff persons may be reassessed by either process up to three (3) times. If the staff person does not pass after three attempts, he/she must complete the full MAP Certification training again and test through the American Red Cross. Staffs who do not pass by either process may not administer medications until they are reassessed and pass a Provider Agency Competency Evaluation or the Red Cross administered skills test or Certification exam.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Recertification Process **POLICY NO: 02-8**
DATE ISSUED: 12/1/03

SEE FORMS ON FOLLOWING PAGES

PROCEDURE FOR MAP RECERTIFICATION
THROUGH PROVIDER AGENCY

Enclosed is an application form for **Recertification** testing. You will need to complete this form and turn it in to the Approved MAP Trainer at the time of your Recertification testing. Once you have passed the Recertification evaluation, and upon the recommendation of you supervisor, your application will be forwarded by your employer to:

American Red Cross Testing Office
MAP Recertification
786 Main St.
Melrose, MA 02176

The American Red Cross will then send your new MAP Wallet Card to you employer and update the MAP Registry.

Your Certification period lasts for two years from the last day of the month in which you passed the Recertification or Certification test. You are eligible to Recertify if you are in good standing on the MAP Registry. To become Recertified, you must complete the enclosed application form and pass the Recertification exam conducted by an Approved MAP Trainer. The Recertification process allows a person to test up to 90 days before expiration of Certification. The expiration date of your Recertification is two years from the last day of the month in which the Recertification test was passed. Once your MAP Certificate expires, you may no longer administer medications.

PROCEDURE FOR MAP RECERTIFICATION THROUGH AMERICAN RED CROSS

Enclosed is an application form for Medication Administration Program (MAP) **Recertification** testing.

Your Certification period last for two years from the last day of the month in which you passed the Certification or Recertification test. You are eligible to Recertify if you are in good standing on the Red Cross Maintained MAP Registry. To become Recertified, you must complete the enclosed application form and pass the Recertification examination. The Recertification process permits a person to test up to 90 days before expiration of Certification. The expiration date of your Recertification is two years from the last day of the month in which the Recertification test was passed. Once your MAP Certificate expires, you may no longer administer medications.

Send your application to:

American Red Cross Testing Office
MAP
786 Main Street
Melrose, MA 02176

What you can expect:

If your application is complete, every attempt will be made to schedule your test within 8-12 business days, but in no event will it be greater than 26 business days from the date we receive your application. You will receive written notification at lease five (5) days before the test date.

If your application is incomplete, it will be returned to you.

On the Test Day:

1. Arrive at the test site 15 minutes before the time you are scheduled. There are two times listed on your Admission Notice. You must attend both times for your Recertification test.
2. Bring two forms of identification. Once must be a current and clear photo ID; such as a driver's license, passport, or employer identification card. Examples of a second ID are; Social Security card, utility bill, Medication Certificate, etc.
3. If you do not bring two forms of identification you will not be tested and will have to reschedule. You must pay a $20.00 fee to reschedule the missed test, unless it is an emergency. You will need to provide documentation of the emergency, such as a doctor's note.
4. If you arrive late for the testing, you will not be tested. You should then send in a written letter requesting to be rescheduled along with the no show fee of $20.00. The fee must be in the form of a money order.
5. Upon completion of the Recertification test, you will be given a Registry Inquiry Form to give to your employer. Your test results will be available to your employer through the American Red Cross website three (3) business days from your test date.

MAP Policy 2-8

MAP Recertification Evaluation Manual

Procedure for Medication Administration Program (MAP) Recertification
by DMH & DMR Provider Agencies

1. Staff seeking Recertification need to complete the *Medication Administration Program Testing Application Form* (see policy 02-5) and present it to an Approved MAP Trainer at the time of Recertification evaluation.

2. Once staff has completed the Recertification evaluation, the Approved MAP Trainer will indicate on the completed *MAP Recertification Competency Evaluation Form* whether the individual is *"Eligible" or "Not Eligible"* for Recertification and sign the form.

3. The signed *MAP Recertification Competency Evaluation Form* and the completed *Medication Administration Program Testing Application Form* should be forwarded to the agency-designated supervisory staff person who:
   a) For a staff person deemed *"Eligible"*, must indicate whether the staff person is *"Recommended"* or *"Not Recommended"* for Recertification; or,
   b) For a staff person deemed "*Not Eligible"*, must indicate that the individual is no longer authorized to administer medications.
   c) Must sign the form.

4. In the event a staff person is no longer authorized to administer medication because they have been deemed *"Ineligible for Recertification"* by the Approved MAP Trainer, the *MAP Recertification Competency Evaluation Form* is to be kept on file by the provider agency and a copy forwarded to the Red Cross.

5. In the event a staff person is *"Not Recommended"* for Recertification by the supervisory staff person, the *MAP Recertification Competency Evaluation Form* should be forwarded to a DMH Area or DMR Regional MAP Coordinator.

6. For a staff person who is deemed both *"Eligible"* and *"Recommended"* for Recertification, his/her M*edication Administration Program Testing Application Form* and *MAP Recertification Competency Evaluation Form*, signed by both the Approved MAP Trainer and supervisory staff person, should be forwarded to:

American Red Cross Testing Office
MAP Recertification Renewal
786 Main Street
Melrose, MA 02176

MAP Policy 2-8

7. Upon receipt of the completed forms, the American Red Cross will send a new MAP Certification Wallet Card to the staff person's employer and update the Red Cross-maintained MAP Registry accordingly.

8. Staff are eligible to Recertify if they are in good standing on the MAP Registry. The Recertification process allows a person to test up to 90 days *before* expiration of Certification. Certification lasts for two years from the last day of the month in which the staff person successfully completed the Recertification test or evaluation. Once a staff person's Certification expires, he/she may no longer administer medications.

9. A staff person may be reassessed in this manner up to three (3) times. (See Policy 02-7).

MEDICATION ADMINISTRATION PROGRAM (MAP)
RECERTIFICATION COMPETENCY EVALUATION FORM

Name:_____ **Social Security #:**_____

Provider Agency:_____

Date of Evaluation:_____

In order to receive a passing score on this test, staff must receive a 'Yes" on every item.

MAP Trainer Recertification check off list: *(To be completed by Approved MAP Trainer only)*			**Comments** *(Continue on reverse side if necessary)*
1. Staff identifies the correct medication sheet (s):	☐Yes	☐No	
2. Staff identifies the correct HCP order (s):	☐Yes	☐No	
3. Staff compares orders to med sheet(s):	☐Yes	☐No	
4. Staff identifies correct medication(s):	☐Yes	☐No	
5. Staff compares med sheet to pharmacy label:	☐Yes	☐No	
6. Staff prepares correct dose(s):	☐Yes	☐No	
7. Staff compares med sheet to pharmacy label again:	☐Yes	☐No	
8. Staff correctly administers medication(s):	☐Yes	☐No	
9. Staff compares med sheet to label again and correctly documents administration:	☐Yes	☐No	
10. Staff stores and manages medications in a secure manner:	☐Yes	☐No	
11. Staff accurately transcribes a HCP order onto the medication administration record:	☐Yes	☐No	

Based on this evaluation, the above-named staff person is for Recertification. ☐***Eligible*** ☐***Not Eligible***

_____ _____

Approved MAP Trainer (print name) *Approved MAP Trainer Signature*

FOR SUPERVISORY SIGN-OFF ONLY

I verify that I have reviewed this form and *(check one block only*)

☐ ***Recommend*** ☐ ***Do Not Recommend*** **the above-named staff for Recertification.**

OR

☐ **Acknowledge that the above-named staff is not eligible to administer medication under the MAP as a result of this evaluation.**

_____ _____ _____

Signature Title Date

MAP Recertification Evaluation Manual

Examiner's Guide for Use with the MAP Recertification Competency Evaluation Form

I. Identifying Information: Either the staff applying for Recertification or the Approved MAP trainer may complete this section.

II. Check Off List: This section is to be completed by the Approved MAP Trainer administering the skills exam. Check "Yes" if the staff person demonstrates the skill correctly. Check "No" if the staff **does not** demonstrate the skill correctly. Comments regarding the individual's performance in regards to a specific skill may be written on the corresponding line under "Comments**".**

1. **Staff identifies the correct medication sheet(s):** When the staff is told by the Approved MAP Trainer the identity of the individual to whom they will administer medications (actual or role play), the staff is able to locate the correct medication administration sheet(s) for that individual.

2. **Staff identifies the correct Health Care Provider (HCP) order(s)**: When the staff is told by the Approved MAP Trainer what medication they will be administering to the identified individual, that staff is able to identify the correct HCP order that matches that medication.

3. **Staff compares orders to medication sheet:** The staff is able to identify the entry on the medication sheet that corresponds with the HCP order identified in #2.

4. **Staff identifies correct medication(s):** Using the HCP order and the medication sheet, the staff is able to retrieve and identify the correct medication from the medication storage unit.

5. **Staff compares the medication sheet to the pharmacy label**: Staff compares the pharmacy label on the medication container to the corresponding entry on the medication sheet and verifies that they match.

6. **Staff prepares correct dose(s):** Staff pours the correct dose of medication and correctly prepares the medication for proper administration (i.e. it may need to be crushed, dissolved or diluted).

7. **Staff compares medication sheet to the pharmacy label again:** Once the medication (s) are poured and prepared, the staff compares the pharmacy label on the appropriate medication container with the corresponding entry on the medication sheet to once again verify that they match.

8. **Staff correctly administers medications:** Staff identifies the correct individual, explains to that individual what medications are being administered, provides that individual with appropriate agent for administration (water, juice, pudding, tissues for eye drops, etc.), verifies that medication was successfully ingested or applied and safely disposes of medication administration supplies.

9. **Staff compares medication sheet to pharmacy label again and correctly documents administration:** Staff is able to identify the entry on the med sheet that corresponds with the HCP order identified in #2. Staff also correctly places their initials in the box corresponding with the date and time of administration. Staff also includes any and all additional documentation that may be indicated as in the administration of a PRN or a countable medication.

10. **Staff stores and manages medications in a secure manner:** Throughout the administration process, the staff demonstrates an understanding that medications must be maintained in a manner that keeps the individuals in that setting safe from accidental or intentional ingestion of those medications. For example, medications are kept with the staff at all times when the storage unit is open and staff secures medications under a lock whenever it is appropriate.

11. **Staff accurately transcribes a HCP order onto the medication sheet:** The staff is given a HCP order that includes a discontinuation of a current medication and pharmacy label (mock) of the newly prescribed medication. The staff is asked to transcribe that order onto a medication sheet. The order for the new medication must be one that is time-limited, in other words, it has a "start" and "stop" date. The staff must demonstrate that they understand all of the components of the HCP order and label and how they correspond to the components on the medication sheet, (i.e. "dose", "amount", "strength", and special instructions.)

III. Eligibility: In order to be deemed "*Eligible for Recertification*", staff must receive a "Yes" on every item on the *MAP Recertification Competency Evaluation Form* checklist. The Approved MAP Trainer who conducted the Recertification evaluation indicates whether the staff is *"Eligible"* or *"Not Eligible"* and prints and signs his/her name on the line at the bottom of the *MAP Recertification Competency Evaluation Form* checklist section. The form is then forwarded to the supervisory staff person.

A staff person who is deemed *"Not Eligible for Recertification"* may no longer administer medications until they are reassessed and pass a skills test, evaluation or Certification exam.

03

TRAINING AND CURRICULUM

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: MAP Trainer Requirements **POLICY NO: 03-1**

DATE REVISED: 1/1/05

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1. Regulations at 105 CMR 700.003(F)(2)(a) require that a trainer be a registered nurse, nurse practitioner, physician assistant, registered pharmacist or licensed physician who meets the applicable requirements for a trainer.

2. The established requirements for a trainer are:
   - Currently licensed as a registered nurse, nurse practitioner, physician assistant, registered pharmacist, or physician in Massachusetts;
   - At least two years of experience in his/her profession;
   - Completion of the DPH approved "Train the Trainer" Program

3. The "Train the Trainer" program will be offered by DPH/DMH/DMR at regularly scheduled intervals.

4. Candidates to become MAP Trainers must provide a resume and proof of current licensure.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Being a Trainer **POLICY NO: 03-2**

POLICY SOURCE: MAP Training Policy **DATE ISSUED: 10/15/97**

Being a Trainer

- To maintain their approval status, trainers must remain current regarding all DPH approved training and testing materials, advisories, policies and other changes through meetings scheduled with a MAP coordinator annually, and as determined by DPH. In addition, trainers must teach at least one training every year.

- Trainers not attending scheduled meetings will be notified that their approval status has been revoked.

- It is the responsibility of the service provider to assure that the trainer of their staff is an approved trainer. After July 1, 1998 applications for staff certifications will not be accepted from trainers who have not met the criteria. Service providers may contact their central office to confirm a trainer's approval.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Training Direct Care Staff **POLICY NO: 03-3**

POLICY SOURCE: MAP Training Policy **DATE ISSUED: 10/15/97**

- Regulation at 105 CMR 700.003(F)(2), 115 CMR 6.06(5) and 104 CMR 15.03(6) require **all** training programs to meet specifications jointly established by DPH, DMH and DMR. As stated in the DPH approved training materials, training programs must not be less than **16 hours** in length, including classroom instruction, testing and the practicum. Trainers must comply with this specification.

- The Medication Administration Program's training program is specific to DMH/DMR registered MAP programs only. MAP trainers may only train those individuals who will be administering medications in registered DMH/DMR adult settings.

- All trainers must use the most recent DPH approved training manual and testing materials. The approved materials will henceforth be marked in the lower left-hand corner with a DPH logo. All training manuals and testing materials must be submitted by DMH and DMR to DPH for approval before use. Recommendations for changes to the training materials by a trainer may be submitted to DMH and/or DMR.

- Staff training and certification is transferable between DMH and DMR only and is valid only in adult DMH/DMR registered MAP programs.

- Because certificates are transferable between all DMH/DMR adult community residential programs, all portions of the training manual must be taught. No part may be eliminated or modified due to a trainer's or service provider's preferences or personal beliefs or for any other reasons. Failure to teach the entire training would lead to inconsistencies in training and qualifications. If DMH/DMR or service provider policies prohibit or discourage use of any portion of the training, (e.g. staff may not administer via a specific route) then staff should be instructed on the specific rules on site. Nevertheless, that portion of the training must be provided as part of the basic training.

MAP coordinators will compile a list of their area/regional trainings for certification and recertification of direct care staff. Private service providers and individual trainers are encouraged to participate. If they choose to do so, then they should submit a list of their trainings to the area/regional MAP Coordinator. Scheduled Area MAP Training forms will be completed by each MAP coordinator and be forwarded to the appropriate Central Office and the clinical reviewer at DPH by the fifteenth of each month. If trainings are scheduled far enough in advance, this may be done on a quarterly basis. Implementation of this process shall begin on November 1, 1997. A copy of a Scheduled Area MAP Training form is attached.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Additional Training for Vital Signs **POLICY NO: 03-4**

POLICY SOURCE: MAP Training Policy **DATE ISSUED: 10/15/97**

- To administer medications that require the monitoring of vital signs for administration, e.g. Digoxin, Inderal, Clorazil, or Tylenol ordered for a fever, certified staff must be proficient in this skill. Training for vital signs is not offered in the MAP training; therefore additional training must be provided to those certified staff whose responsibilities include monitoring of vital signs for medication administration. Regulation at 105 CMR 700.003(F)(1)(b) states "…that medication is administered only by properly trained and certified personnel." Furthermore, regulation at 105 CMR 700.003(F)(2) states that these personnel must have successfully completed "a training program which meets the specifications for a training curriculum … established jointly by the Department of Public Health and the Department of Mental Health and/or Department of Mental Retardation".

- Service providers are responsible for (1) obtaining instructions from physicians regarding the need for monitoring of vital signs for medication administration; (2) obtaining specific, written parameters for vital signs, if appropriate; (3) training their staff to take vital signs; and (4) maintaining a current list of trained and competent staff that includes the name(s), address (es) and telephone number(s) of the trainer(s). This list should be maintained both at the site and in the provider's main office

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POLICY ISSUE: N/A **POLICY 03-5**

DATE ISSUED: N/A

Policies 02-7 and 02-8 replaced Policy 03-5 in December 2003

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Specialized Training Programs **POLICY NO: 03-6**

DATE ISSUED: 1/1/05

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1. The regulation at 105 CMR 700.003(F)(5)(e) requires staff to have successfully completed a specialized training program prior to administering "parenteral drugs generally intended for self administration, or drugs administered by gastric tube". Such training programs must be approved by the Department of Public Health and the Departments of Mental Health and/or Mental Retardation.

2. At present there are no approved specialized training programs for parenteral drugs with the exception of Epi-pen (epinephrine). See policies 14-1 through 14-4 for instructions regarding Epi-pen training. Proposals for any additional specialized trainings must be submitted to DMH and/or DMR for review and approval prior to submission to DPH for final approval.

3. Please see Policy 14-5 for required forms and instructions regarding the approved specialized training requirements for medications administered by MAP Certified staff via gastrostomy or jejunostomy tube.

04

ROLE OF NURSING

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Role of Nursing in MAP **POLICY NO: 04-1**

POLICY SOURCE: 1997 BoRN Advisory **DATE ISSUED: 2/16/94**
DATE REVISED:05/14/97

Board of Registration in Nursing
Advisory Ruling

Nursing Practice Related to Medication Administration by Certified Program Staff
in Community Residences - Departments of Mental Health and Retardation

This Advisory ruling is issued to guide the practice of Registered Nurses and Licensed Practical Nurses employed in, or employed as nurse consultants to, community residences under the auspices of the Massachusetts Department of Mental Health and/or Department of Mental Retardation.

The areas of nursing practice covered in the Board's Advisory Ruling include:

1. Teaching the curriculum for the certification of program staff in medication administration;
2. Accountability for medication administration to clients for whose care the nurse is responsible;
3. The role of nurses who provide episodic care to clients, but who are not responsible for the client's overall care;
4. The requirement for a valid order from an authorized prescriber prior to administering medication;
5. The duty to report observed, inappropriate medication administration by certified staff;
6. Providing technical assistance and advice, as in regulations at 115 CMR 6.06 (6) (f), and 104 CMR 15.03 (6) (h) (9); and
7. The role of the nurse consultant under the Medication Occurrence Reporting System, implemented 12/01/96.

Teaching the Curriculum for Medication Administration Certification

- Nurses deemed qualified by the Departments of Mental Health (DMH) or Mental Retardation (DMR) to teach the established program of instruction for medication administration may instruct unlicensed program staff in the didactic and practical components of the program leading to certification in medication administration.

- The nurse instructor does not bear on-going accountability for the practice of the staff person who is certified under the standards established by DMR and/or DMH.

- Nurses who have not been trained as instructors for the DMR/DMH medication administration program should not participate in supervising or monitoring the initial administration of medications to clients by newly certified staff.

- Monitoring of initial medication administration is not a formal part of the DMR or DMH training program. However, the Board strongly supports such supervision by qualified nurse instructors. This does not constitute delegation of medication administration by the nurse instructor.

Accountability for Medication Administration to Clients for Whose Care the Nurse is Responsible

- Nurses shall not delegate, assign or allow unlicensed, certified staff to administer medications to clients for whose direct care the nurse is responsible. When a licensed nurse is responsible for a client's direct care, such responsibility shall include administration of all medications.

- In residences where program staff are responsible for direct care provided to certain clients, and licensed nurses are responsible for direct care provided to other clients, the nurse shall only be accountable for administration of medications to clients for whom he/she has direct responsibility or for medications the nurse personally administers to any other client.

- Administration of medications by certified program staff to clients for whom the certified staff person has direct care responsibility, is not considered delegation and/or supervision, as defined in 244 CMR 3.05, by a nurse who is providing care to other clients in the same residence.

- A licensed nurse is only accountable for the medications he/she administers. A nurse is not accountable for medications administered by certified direct care staff.

Medication Administration and the Nurse Who Provides Episodic Care

- Nurses who provide episodic care to clients in DMR and/or DMH community residences include nurses employed by Visiting Nurse Associations or home health agencies, as well as nurses employed by DMH and/or DMR for the purposes of intermittent or episodic health assessment and nursing intervention. For the purposes of this Advisory, the nurse functioning in this role is not the care provider responsible for managing or supervising overall client care, and is not accountable for medication administration by certified program staff.

Providing Technical Assistance and Advice
115 CMR 6.06 (6) (f) and 104 CMR 15.03 (6) (h) (9)

- Nurses who are employed by DMR and/or DMH to provide or arrange for technical assistance and advice, as described in the regulations noted above, shall provide assistance about *systems* related to medication administration issues as required. Examples of **systems** include, but are not limited to transcribing, ordering, procuring, documenting, destroying and storing of medications.

- Questions about client care problems related to medications shall be directed or referred to the appropriate licensed practitioner (MD/NP/PC) either via telephone, of floe visit, clinic visit, or emergency room visit, or the appropriate emergency response system, per Department of Public Health policies.

Nurse's Requirement for a Valid Medication Order

- The Nurse Practice Act requires nurses to have an order from an authorized **prescriber prior** to administering ALL prescription and non-prescription (over-the-counter) medications.

- Medication orders transcribed by an unlicensed person must be verified by a licensed nurse prior to being implemented by a nurse. Methods of verification vary, and should comply with written employer policies.

- A nurse who accepts a verbal/telephone order relayed by an unlicensed staff person may implement the order. The nurse is accountable for her practice in this matter. This includes ensuring that the orders originate from an authorized prescriber and ensuring that any orders he/she carries out are reasonable based on the nurse's knowledge of the client and his care needs. If at any time the nurse has a question about the appropriateness of an order, the nurse is accountable for clarifying the order with the original prescriber.

- As evidence of a valid medication order, a nurse may use a pharmacy-labeled medication container that includes the client's name, the name and phone number of the pharmacy, the name of the prescriber, the name of the medication, the dose and route of administration, the frequency and/or time of medication administration, the date of the order and the discontinuation date, and any specific directions for administration.

Nurses' Duty to Report Inappropriate Medication Administration

- Nurses who observe inappropriate activities related to administration of medication by certified program staff should follow the established Department of Mental Health/Mental Retardation and Department of Public Health policies for reporting these occurrences.

Role of the Nurse Consultant under the Medication Occurrence Reporting (MOR) System, Implemented 12/01/96

- Department of Public Health (DPH) policy for medication occurrence reporting includes contacting a professional consultant (registered nurse, pharmacist, other licensed practitioner) in the event of an occurrence involving medication administration that is inconsistent with the practitioner's prescription.

- According to DPH policy, the consultant contacted as the result of a Medication Occurrence will recommend action (medical intervention), including: lab work or other tests; physician visit; clinic visit; emergency room visit; hospitalization; and other recommendations, as noted on the MOR reporting form.

- When the consultant is a Registered Nurse (R.N.), the nurse's legal scope of practice permits him/her to recommend: a) contact with the appropriate licensed practitioner (MD/NP/PC) either via telephone, office visit, clinic visit or emergency room visit; and/or b) calling the appropriate emergency medical response system.

- A nurse consultant may recommend consultation with a MAP Coordinator or another consultant.

- It is not within R.N. scope of practice to order that lab work or other tests be performed. An R.N. may recommend to the reporting staff person that an appropriate provider be contacted to order any lab work/test that may be indicated.

- It is not within R.N. scope of practice to order hospitalization of a client.

- It is not within R.N. scope of practice to recommend that a medication dose be adjusted, i.e., increased, decreased, omitted or repeated.

An R.N. consultant who is an authorized advanced practice nurse (UP, NM, or Psychiatric Clinical Specialist) may prescribe and order tests and therapeutics, consistent with the nurse's legal scope of advanced practice and with the individual nurse's written practice and prescribing guidelines.

05

CONSULTANTS

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Role of Consultants in MAP **POLICY NO: 05-1**

POLICY SOURCE: MAP Consultant Policy **DATE ISSUED: 04/97**

Utilization of Consultants in the Medication Administration Program

For the purposes of the Medication Administration Program (MAP), the consultant is a professional, knowledgeable and skilled in medication administration systems, who provides technical assistance and advice to certified staff. Regulations at 105 CMR 700.003(F)(1)(g) require that the professional consultant be a registered nurse, registered pharmacist or practitioner.[1]

Consultants provide advice, assistance and recommendations and answer questions on medications and on issues regarding medication administration systems. This may include, but is not limited to:

- Interpreting a practitioner's prescription for the staff;
- Providing information on a medication's indications for use and side effects; and
- Recommending appropriate actions to follow a medication occurrence (error involving the wrong medication, individual, dose, time or route of administration).

The information that the consultant supplies to the direct care staff is broad-based, general information that does not require, but does not preclude, direct observation, information on the client's/consumer's medical history, or direct follow-up. Consultants function within their scope of practice (e.g. a registered nurse or pharmacist could clarify for staff a physician's medication order but only a licensed practitioner could order lab work). If the consultant believes that he/she has insufficient information and/or knowledge to make a recommendation concerning a particular occurrence, then the consultant should recommend that the direct care staff contact the prescribing practitioner, dispensing pharmacist, or another MAP consultant who is better able to provide information to the staff.

MAP is a direct authorization model under which certified staff function in accordance with the orders of a licensed practitioner. Consultants do not control, supervise or monitor certified staff's medication practices. The service provider, not the consultant, is responsible for the direct care of the client/consumer, including medication administration by the certified staff.

In addition to the requirement that certified staff have 24-hour access to a consultant, MAP policies require that consultants be contacted for every medication occurrence. This ensures that in the case of a medication occurrence certified staff will have:

- Access to the technical assistance they need to interpret the practitioner's prescription;
- Information on appropriate actions following an occurrence; and

[1] Regulations at 105CMR 700.001 define in part a practitioner as a physician, dentist, podiatrist, or other person (e.g. nurse practitioner, psychiatric nurse clinician, physician assistant, nurse midwife) who is registered to prescribe controlled substances in the course of professional practice.

- Guidance regarding the medication occurrence reporting process should they require it.

In the case of a medication occurrence, the DPH registrant (the service provider) has the responsibility to:

- Document on the MOR form that a consultant has been contacted;
- Determine whether or not an occurrence has happened;
- Determine what, if any, action(s) will be taken by direct care staff to care for the client/consumer; and
- Report to DPH/DMH/DMR within the established time frames.

Consultants, while required to provide technical assistance in these matters, are not expected to make these determinations or file reports with DPH/DMH/DMR.

Consultants should make independent arrangements with the program(s) they serve. A letter of agreement between the program and the consultant that describes the consultant's role and responsibilities is strongly recommended.

06

MEDICATION ADMINISTRATION

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Administration of Insulin & Medications via G-tube/J-tube

POLICY NO: 06-1

DATE ISSUED: 1/1/05

- MAP Certified staff must have completed a specialized training program approved by DPH before they may administer medications via G-Tubes/J-tubes and/or parenteral/injectable medications, including both insulin and epinephrine. **See Policy 3-6 regarding training for Certified staff in the administration of epinephrine (Epi-pen) and/or medications via G/J tube.** At this time, there is no approved program to train Certified staff to administer insulin. This does not, however, preclude Certified staff from monitoring those individuals who self-administer their insulin as long as syringes are either filled by client/consumer or pre-filled by licensed individuals or the manufacturer.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: PRN Medications **POLICY NO: 06-2**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 04/97**
DATE REVISED: 9/1/98

- Physician orders for all PRN medications must have specific target symptoms and instruction(s) for their use (e.g. Tylenol ii tabs po q4 hrs. prn for a fever >101). Certified staff may administer PRN medications only according to the practitioner's prescription and not according to any assessments or medical decisions/judgments independently made by them or other direct care staff. For instance, in the above example, the order for Tylenol could not be given for a headache.

- If PRN orders are unclear, the consultant must be contacted.

- Administration of PRN medications requires additional documentation in a client's/consumer's progress notes, on a medication comment sheet/log, or on the reverse side of the medication sheet explaining the reason for its use and providing information on the medication's effectiveness.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Pre-filling of Syringes **POLICY NO: 06-3**

POLICY SOURCE: December 1994 MAP Advisory **DATE ISSUED: 12/94**

- Pre-filling syringes is allowed when performed by licensed individuals. However, there are conditions that must be adhered to when pre-filling syringes. Namely, all syringes, including pre-filled syringes, must be stored in a secure area when not needed, kept on "count", and unlicensed staff must have specialized training to administer parenteral/injectable medications. Thus, until a formal advanced certification process is implemented, administration of injectables to non-self-medicating individuals must be done by a licensed individual.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Pre-pouring/Pre-packaging of Medications **POLICY NO: 06-4**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 04/97**

- Regulations of the Department of Public Health at 105 CMR 700.003(F)(3) requires all programs to maintain adequate storage, security and handling of medications. Therefore, medication is never to be prepared at any time except immediately prior to the administration of that medication. When a medication is "pre-poured" by staff, the integrity of that medication can no longer be guaranteed.

- Certified staff are not permitted to pre-pour or pre-package medications, except as directed under the LOA policy, or to administer medications poured or pre-poured by another individual including certified or licensed persons.

- Included among these prohibited activities is the setting up of medication planners and the pre-pouring of medications for training purposes. This does not preclude staff from monitoring consumers/clients who set up their own medication planners.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Medication Administration Times **POLICY NO: 06-5**

POLICY SOURCE: 1997 DMH Memorandum **DATE ISSUED: 8/14/97**

- Programs must have a medication policy & procedure describing its administration times for medications, which should include information on qd medications. Physicians' Orders are not required to have exact administration times, however, the physician may choose to specify this information. Orders stating the frequency as bid, tid, etc., are acceptable. For qd medications, programs should seek clarification from the physician when the qd medication should be given.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Vital Signs **POLICY NO: 06-6**

POLICY SOURCE: Policy Manual **DATE ISSUED: 9/1/98**

Vital Signs

Although health care providers are ultimately responsible for individuals under their care, the Departments acknowledge the important ongoing role service providers have in consulting with health care providers regarding matters such as medication administration. Routine consultation by service providers with an individual's health care provider regarding medication administration and the possibility for the need to monitor vital signs for safe administration provides for continuous quality of care that ensures safe and effective medication administration.

In addition, regulations of the Department of Public Health at 105 CMR 700.003(F)(1)(b) state "The program shall establish, maintain, and operate in accordance with policies which ensure that medication is administered only by properly trained and certified personnel." To administer medications that require the monitoring of vital signs for administration, e.g. Digoxin, Inderal, Clorazil, or Tylenol ordered for a fever, certified staff must be proficient in this skill.

Presently there is no mechanism in place to readily determine if vital signs are required for administration of a particular medication. Moreover, current MAP curriculum does not include training of certified staff in the taking of vital signs. Since vital signs may be required for some medication administration, service providers must develop a policy addressing vital signs and must ensure that their staff are properly trained as needed so that medications are administered appropriately and safely. This policy must:

1. Include a method(s) developed by the service provider to assure that written instructions, if needed, are obtained from the health care provider(s) regarding the need for monitoring of vital signs for medication administration. The method(s) developed by the service provider must clearly state whether vital signs are or are not required for medication administration. This may be easily met by adding a question to the health care provider consult form, e.g. "Please document if you wish to have vital signs taken before the administration of any of these medications."

2. State whether the training offered by the provider will be consumer specific, program specific or general in nature.

3. List the equipment to be used by staff to monitor vital signs, e.g. digital equipment, glass thermometer, stethoscope.

4. Specify the appropriate documentation of staff training. Documentation must include the date of the training, name(s) of staff trained, and the name, address and telephone number of the trainer(s).

5. Require that specific, written parameters be obtained from the health care provider if vital signs are required for medication administration. This also may be added to the health care provider consult form, e.g. "If vital signs are required, what parameters do you wish?"

6. Require proper documentation of vital signs on the Medication and Treatment sheet, including documenting vital signs below the initials of the certified or licensed staff administering the medication.

7. Include guidelines for follow-up with the Health care provider if vital signs are outside of the established parameters.

8. Require documentation of the notification of the health care provider and any follow-up instructions/orders received.

MAP Policy 6-6

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Allergies **POLICY NO: 06-7**

POLICY SOURCE: 1997 DMH Memorandum **DATE ISSUED: 08/14/97**
DATE REVISED: 9/1//98

All allergies must be listed on the following:

- Medication and Treatment Sheet (all pages, every month)
- Physician Consult Form
- Emergency Information Sheet
- All other appropriate forms

MEDICATION ADMINISTRATION PROGRAM
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POLICY ISSUE: Blood Glucose Monitoring **POLICY NO: 06-8**

POLICY SOURCE: 1998 DMH Letter **DATE ISSUED: 02/24/98**
DATE REVISED: 04/98

The care of an individual with Diabetes has changed tremendously over the past decade. Today, blood glucose monitoring is performed in the home setting by either the individual or the caregiver and assists the health care provider in providing the most up-to-date care to these individuals. DMH/DMR community residential programs that conduct blood glucose monitoring must adhere to the following:

- Certified staff may perform blood glucose monitoring using "fingersticks", e.g. *Accuchecks*, in accordance with a health care provider's order provided the staff person first receives instruction in the equipment and procedure involved from a licensed nurse.

- Training and competency must be appropriately documented and maintained at the service provider's main office and on site.

A service provider may wish to use their own nurse for this training or, if the service provider does not employ a nurse, may wish to use a nurse from a Visiting Nurse Association or Home Health Agency or staff at the health care provider's office.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Over-the-Counter Medications and Preparations **POLICY NO: 06-9**

DATE ISSUED: 1/1/05

While Over-the-Counter (OTC) medications and preparations may have fewer regulatory controls than prescription medications, they may have significant medical impact especially when an individual is taking prescription medications along with OTC medications.

I. All OTCs require a Health Care Provider order. The labels for OTC medications and preparations must be managed in one of the two following ways as described in *either* "A" or "B" below:
   A. A label is applied by the pharmacy or Health Care Provider as prescription medications are labeled; *or*,

   B. If not labeled by the pharmacy or Health Care Provider, then:
      1. The OTC medication or preparation must be in the original manufacturer's container with the original manufacturer's label affixed, *and,*

      2. A licensed person must verify that the contents of the container reflects the Health Care Provider's order by:
         a) Comparing the manufacturer's label to the Health Care Provider order and verifying the contents by initialing the container
         b) Placing the individual's name on the container
         c) Placing the date of verification on the container
         d) Noting the verification on the HCP order I (B)(2)(a-d) must be performed every time a new container of the medication or preparation is obtained; and,

      3. Because MAP Policies and trainings do not train staff to administer medications and preparations without pharmacy or HCP labels then:
         a) The service provider must have in place policies regarding the administration of OTCs without pharmacy or HCP labels within their programs; and,
         b) All Certified staff must be trained by the service provider to administer medications and preparations from a container without a pharmacy or HCP label and such training must be documented.

II. Regardless of whether method I "A" or "B" is used, the following applies to all OTC medications and preparations:
   A. Certified staff must document the administration of OTC medications and preparations in the same manner as prescription medications are documented.
   B. OTC medications and preparations must be stored in the same manner as the prescription medications.

C. An OTC medication and preparation that is not administered according to the Health Care Provider's order is a medication occurrence and must be reported to DMH/DMR/DPH per the requirements of the Medication Occurrence Reporting System.

MAP Policy 6-9

07

SELF-MEDICATION

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Definition & Criteria for Self Administration of Medications

POLICY NO: 7-1

DATE REVISED: 1/1/05

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1. DPH, DMH and DMR each supports the concept of individual self-administration of medications whenever feasible. Nothing in the MAP regulations should be viewed as an impediment to an individual's transition to self-administration. If an existing policy inhibits the goal of self-administration, it should be brought to the attention of the DPH for review.

2. While different programs may, for the purposes of case management, use various terms to denote stages of an individual's transition to self-medication, for the purposes of compliance with MAP regulations an individual is self-medicating, by definition, only when the medication is under the complete control of the individual with no more than minimal assistance from program staff. For individuals who are non-self-administering their medications or in transition and do not meet the above criteria, MAP Certified or licensed staff will be responsible for documenting medication usage and ensuring its security.

3. Verbal reminders to self-administering individuals are permissible by regulation. Reminding and prompting an individual to take their medication does not, in and of itself, require licensed or Certified staff. However, some staff training is recommended.

4. **Criteria for Self-Medication**

In order to be considered self-medicating an individual must demonstrate an ability to take medications independently. This is evidenced by:

a) An ability to store his/her medication so that it is inaccessible to others
b) An understanding of the type of medication, its purpose and for what symptoms or condition it is being prescribed
c) Knowledge of the frequency of doses (verbal reminders may be used)
d) A familiarity with the most common side effects of the medication, if any

5. **Individuals who self-medicate:**

a) Do not store their medications with those of non-self-medicating individuals unless it is required to protect the safety of other consumers
b) Do not need to document their medication self-administration
c) Do not have Medication Occurrence Reports (MORs) filed on their behalf

6. **For individuals who are self-medicating, staff may:**

a) Verbally remind them to take their medication.
b) Do a periodic inventory of their medications.

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POLICY MANUAL

POLICY ISSUE: Learning to Self-Medicate **POLICY NO: 07-2**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 04/97**

DMH/DMR regulations at (104 CMR 16.07, 115 CMR 6.00) regarding community residential programs require a clinical team to develop a teaching plan for clients/consumers who are learning to self-medicate in the ISP and/or PTSP that includes goals to be achieved within a specified time frame and a plan of action for obtaining medications consistent with MAP regulations. For the purposes of DPH regulations for MAP, individuals who are learning to self-medicate are considered to be non-self- medicating and DPH regulations at 105 CMR 700.000 apply. The LOA policy may not be used to cover the pre-pouring of medications for the purpose of training consumers/clients in self-medication or for any other reason other than the actual unscheduled LOA.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Appropriate Use of Pill Dispensers **POLICY NO: 07-3**

POLICY SOURCE: 1997 DMH Memorandum **DATE ISSUED: 08/14/97**
DATE REVISED: 9/1/98

Repackaging of medication by the consumer is permissible if the consumer is learning to self medicate according to a documented Program Specific Treatment Plan (PSTP) or Individual Service Plan (ISP) developed by the clinical treatment team. (See DPH Advisory dated 4/15/97)

1. If the consumer is repackaging medications, the PSTP/ISP must include specific steps and a time frame within which an individual will meet his/her goals.

2. Based upon a consumer's skill assessment, documentation from the prescribing health care provider(s) indicating approval for self administration of medications for the period identified in the PSTP/ISP training plan may be required. This documentation must include the number of days an individual may hold his/her medications.

3. The medication container/pill dispenser must be clearly labeled to include consumer name, prescriber's name, medication name, dosage, administration instructions, and cautionary statements, if any.

4. Consumers must be provided with written medication information sheets.

5. Programs should document the packaging and transfer of medications to the consumer on an observation sheet and/or progress note. Documentation should indicate that medication was packaged by the consumer, date medication was packaged/transferred by the consumer, initials of the certified staff supervising consumer repackaging, and name, dosage, and quantity of medication dispensed.

6. Programs may have staff sign initials on observation sheet indicating pill dispenser was returned by consumer empty to indicate consumer took their medication.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Skill Assessment **POLICY NO: 07-4**

POLICY SOURCE: Supervisor's Training Manual **DATE ISSUED: 05/15/98**

In preparation for the ISP/PSTP a health skills assessment will be completed for all individuals. If this assessment indicates that the individual could benefit from learning self-medication, a team including staff, a nurse consultant if available and the individual will participate in specifically assessing the individual's self-medication. There are a number of Self-Medication Assessment forms available throughout the state.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Development of a Teaching Plan **POLICY NO: 07-5**

POLICY SOURCE: Supervisor's Training Manual **DATE ISSUED: 05/15/98**

- The Assessment of Self-Medication Skills is the basis for developing a medication skills teaching plan. The individual's physician will prescribe the correct medication and monitor its effectiveness. It is recommended that the physician also be included in the decision to begin teaching self-medication skills. This may require some explanation of the methods used to teach and what kind of supervision and monitoring will be used to ensure that the person receives the correct medication as prescribed.

- The training plan will be individualized and will be documented in the ISP or PSTP.

- Documentation must include specific steps and a time frame within which the consumer will meet his/her goals. In accordance with the ISP/PSTP systems, there will be quarterly reviews.

- Staff may not pre-pour medication for individuals who are learning to self-medicate. Individuals may, under the supervision of certified or licensed staff pour their own medication into appropriately marked weekly medication containers.

- If use of a weekly medication container is to be part of their self-medication plan it should be one of the first steps that they learn.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Documentation **POLICY NO: 07-6**

POLICY SOURCE: Supervisor's Training Manual **DATE ISSUED: 5/15/98**

Until individuals meet the criteria for self-medicating status, staff should witness the individual preparing and taking medication. If a weekly pill dispenser is used in the process of learning to self-medicate, staff should document the packaging by the consumer of his/her medications on an observation sheet and/or progress note. Documentation should indicate that medication was packaged by the consumer, date medication was packaged, initials of the certified staff supervising consumer repackaging and name, dosage and quantity of medication packaged. A Medication and Treatment sheet may be used for this purpose if it clearly states that staff is observing the consumer in the preparation and self-administration of his/her medication.

Certified staff may not sign off on the Medication and Treatment sheet that a medication has been administered unless staff actually administer a consumer's medication. Certified staff may; however, sign that he/she has observed a consumer take the appropriate medications. Again this may be clearly noted on a Medication and Treatment sheet.

If programs wish to monitor and document the inventory of a weekly pill dispenser, if used by the consumer in the process of learning to self-medicate, certified staff may do so by placing his/her initials in the appropriate space on an observation sheet or by making note in a progress note.

Some individuals may find a daily calendar or check-off sheet helpful in keeping track of their own medications. This can also serve as documentation during the training process.

The progress of the training program will be documented on a data collection sheet and in quarterly review notes.

The Service Coordinator and Program Director, in consultation with the individual's health care provider, will decide when an individual is reliably self-medicating as described in the ISP/PSTP. A 6-month training period with close supervision is recommended with weekly pill counts for another 3 months.

After this time, the individual's should be reviewed at least at 3-month periods. An individual's completion will be recorded on the Self-Medication Assessment form. At any point, an individual who has decompensated may go back to an earlier time in the training process. It is recommended that a written plan be completed for all self-medicating individuals detailing needed supports, oversight required and the plan to follow if the individual becomes unable to safely self-medicate for some reason.

If an individual who does not usually take daily medication is put on medication for a short period of time (such as an antibiotic), that individual will not be considered self-medicating and will be monitored by staff. If a medication is ordered long-term, a formal training plan will be developed to help the individual learn the necessary self-medication skills.

DOCUMENTATION of Self-Medication Teaching would include the following:

- Appropriate documentation by certified or licensed staff in a progress note, on an observation sheet, or on a Medication and Treatment sheet that clearly identifies the specific role of the staff in the process of learning to self-medicate.

- Documentation by an individual consumer on a calendar with large boxes is acceptable—(the medication names, dosage and times should be written accurately by a staff member).

- Assessment of Self-Medication Skills.

- ISP/PSTP goals or teaching plan and date sheets).

- Documentation of the supports needed for the person to continue to be self-medicating including the plan for monitoring accuracy of self-medication and plan to follow if the person becomes unable to safely self-medicate, Documentation of the supports needed for the person to continue to be self-medicating including the plan for monitoring accuracy of self-medication and plan to follow if the person becomes unable to safely self-medicate.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Sample Self-Medication Teaching Plan **POLICY NO: 07-7**

POLICY SOURCE: Supervisor's Training Manual **DATE ISSUED: 5/15/98**

SEE FORM ON FOLLOWING PAGE

SAMPLE

SELF-MEDICATION TEACHING PLAN FOR:_____DATE:_____

GOAL: Self-medication: (specify what that will mean for this individual):

Medication Administration skills to be addressed (Take from Assessment of Self-Medication Skills)

Learning Objective:

Teaching Plan/Documentation:

MAP Policy 7-7

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Sample Self-Medication Support Plan **POLICY NO: 07-8**

POLICY SOURCE: Supervisor's Training Manual **DATE ISSUED: 5/15/98**

SEE FORM ON FOLLOWING PAGE

SAMPLE
SELF-MEDICATION SUPPORT PLAN

NAME:_____
DATE:_____

ASSESSMENT OF SELF-MEDICATION SKILLS COMPLETED ☐
Individual must demonstrate competence in all* areas in order to be considered self-medicating.

SUPPORTS NEEDED:
- ☐ Takes pills from pill bottles
- ☐ Weekly pill container
- ☐ Medication chart-individual puts check on chart or calendar when medication is taken.
- ☐ Prompts needed
- ☐ In person: when_____
- ☐ Aids: timer, watch etc._____
- ☐ Other

_____
_____

HOW IS SELF-ADMINISTRATION OF MEDICATION MONITORED?
- ☐ Observe each time medication is taken
- ☐ Check of weekly pill container
- ☐ Periodic pill count
- ☐ Review of individual's medication chart or calendar
- ☐ Other

_____
_____

WHAT SYSTEM WILL BE USED IF THE INDIVIDUAL IS UNABLE TO ACCURATELY SELF-MEDICATE FOR A TIME?

- ☐ Staff will administer medication from labeled bottles or cards
- ☐ Weekly pill container will be checked (Note how often _____)
- ☐ Other_____

_____
Describe plan to help individual regain independence in self-medication:
_____
_____
_____

_____ _____
Individual Date

_____ _____
Case Manager Program Director

MAP Policy 7-8

08

MEDICATION OF MINORS

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Administration to Minors by Certified Staff **POLICY NO: 08-1**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 04/97**

DPH regulations at 105 CMR 700.003 implementing MAP refer to medication administration by certified staff to adult clients/consumers. The regulations do not set the criteria for medication administration to individuals under the age of 18 years of age. Direct care staff are not trained nor certified under MAP to administer medications to individuals under the age of 18 years.

09

MEDICATION OCCURENCES

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Definition of Medication Occurrence POLICY NO: 09-1

POLICY SOURCE: October 1996 MAP Advisory DATE ISSUED: 10/96

- For the purpose of reporting, a medication occurrence is defined as an event that results from a breach of one of the five "R's", namely right individual, right medication, right time, right dose and right route. There are five types of reportable occurrences --"the five wrongs" are listed on the reporting form: wrong individual, wrong medication (which includes administering a medication without an order), wrong time (which includes a forgotten dose), wrong dose and wrong route. (Refer to the Training Manual, Chapter 3).

- The definition of "right time" has been clarified to include medications administered "within the appropriate time frame". This permits a consultant designated by the program to help determine if an occurrence has taken place by using the practitioner's prescription as his/her guide and to recommend an intervention if needed. The determination of whether an occurrence has taken place is the responsibility of the program in conjunction with the consultant, and is based upon the practitioner's prescription, not solely upon the program's or site's medication schedule. For example, a medication ordered BID is not necessarily a reportable occurrence if it is given at 8A.M. and 8P.M. rather than at the times of 8A.M. and 5P.M. scheduled by site staff.

- Events that are not within the staff's control, such as medications missed due to an individual's refusal or absence, no longer require reporting via an MOR. Nevertheless, service providers should have internal reporting procedures for refusals and similar events in order to maintain appropriate care and quality assurance standards. This change will result in an estimated 60% to 70% reduction in occurrences that are deemed reportable.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Use of MAP Consultant **POLICY NO: 09-2**

POLICY SOURCE: October 1996 MAP Advisory **DATE ISSUED: 10/96**
April 1997 MAP Advisory **DATE ISSUED: 4/97**

A Professional Consultant (registered nurse, registered pharmacist or licensed practitioner) must be contacted whenever there is a Medication Occurrence.

- Regulations at 105 CMR 700.003(F)(1)(f) define the professional consultant as a registered nurse, registered pharmacist or licensed practitioner. Licensed practitioner is defined in the regulations as a physician, dentist, podiatrist, or other person (e.g. nurse practitioner, psychiatric nurse clinician, midwife) who is registered to prescribe controlled substances in the course of professional practice.

- A professional consultant must be available to direct care staff 24 hours a day, seven (7) days per week.

- Professional consultants must be contacted for every medication occurrence. The consultant will help the staff determine if an event is a medication occurrence based upon the practitioner's prescription; will assess if harm may have been incurred by the consumer/client; and will recommend to staff the appropriate medical intervention, if any, to be taken.

- Professional consultants shall:

    1) Provide staff with the technical assistance they require to interpret the practitioner's prescription;
    2) Recommend appropriate action(s) to follow a medication occurrence; and 3) provide the staff with guidance regarding the reporting process should they require it.

- The DPH registrant (the service provider) has the responsibility to determine whether or not there has been an occurrence; to determine what, if any, action(s) will be taken by staff to care for the client/consumer; and to report to DPH/DMH/DMR within the established time frames.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Requirements for Reporting Medication Occurrences **POLICY NO: 09-3**

DATE REVISED: 1/1/05

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1. A Medication Occurrence Report (MOR) must be submitted for any reportable Medication Occurrence.

2. Those Occurrences that are followed by a medical intervention, illness, injury or death are reportable directly to DPH via the MOR Hotline process **(**see Policy 16-1 for contact information) within 24 hours of the Occurrence.

3. There need not necessarily be a demonstrated causal relationship between the Occurrence and the medical intervention, illness, injury or death in order for an Occurrence to be reportable to DPH. When in doubt about the status of an Occurrence, contact DPH. Submission of an MOR does not constitute an admission that a medication error caused or contributed to the Occurrence.

4. Copies of all MORs, including those separately reported to DPH via the Hotline process, must be forwarded within seven (7) days to the appropriate DMH/DMR Area or Regional MAP Coordinator.

5. It is strongly recommended that service providers maintain their own internal reporting procedures to identify and address medication related issues, concerns or problems as part of a system of providing appropriate care and quality assurance standards.

6. DPH will inform DMH/DMR of those Medication Occurrences reported directly to DPH via the Hotline process.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Medical Intervention **POLICY NO: 09-4**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 4/97**

Recommended Action(s)/Medical Intervention(s) does not include contacting the consultant nor does it include adjustments made to the medication regime (e.g. skipping the missed dose and administering next dose as scheduled.). These should be marked as "none" in the recommended action(s) section of the MOR form. However, medical intervention does include medical care provided to the client/consumer (e.g. lab work, a visit to the doctor, clinic, hospital, emergency room).

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Medication Occurrence Reporting (MOR) Form **POLICY NO: 09-5**

POLICY SOURCE: October 1996 MAP Advisory **DATE ISSUED: 10/96**

- The new reporting form (MOR) requests information in a manner that reduces the paperwork burden on service providers and facilitates tracking and review by state agencies. The form is user friendly requiring no narrative statement from direct care staff and minimal narrative notes from the supervisor. The form is designed to facilitate appropriate reporting, allow the collection of relevant information and improve the ability to track and respond to medication occurrences. Direct care staff completing the form do not need to sign neither their name nor state the staff person involved in the occurrence. The responsibility lies with the supervisor to review the occurrence, check off contributing factors (if any), comment (optional) and forward a copy of the MOR to the appropriate agency within the assigned time frames. Original forms remain at the site.

- A medication occurrence report is only used for an error by certified staff administering medications and therefore does not need to be completed for self-medicating individuals.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Instructions for Completion of MOR Form **POLICY NO: 09-6**

POLICY SOURCE: October 1996 MAP Advisory **DATE ISSUED: 10/96**

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1. The MOR form must be complete! Fill in all areas before the MOR is faxed to DPH or forwarded to DMR/DMH. Incomplete forms will be returned. Keep original MOR's at the site.

2. Complete the MOR after the consumer/client's immediate needs for care or medical intervention have been met.

3. The first section requests basic information that permits DPH/DMH/DMR to identify the agency, site and consumer/client. Please include the site's telephone number with area code and your DPH registration number since these numbers will be used by DPH/DMH/DMR as identifiers for tracking purposes.

4. To complete the "Type of Occurrence" section, check the occurrence that has taken place. If staff are unsure whether an event is reportable or what type of occurrence should be checked, staff should clarify this with the consultant when the consultant is contacted.

5. List the medications involved in the occurrence in the "Medication(s) Involved" section. Write the medication ordered by the practitioner next to "As ordered". Write the exact medication, dose, frequency/time, and route by which the medication was actually given to the consumer/client next to "As Given". The section allows room for three medications to be listed. List additional medications on the reverse side of the MOR using the "As Ordered/As Given" format.

6. Under the "Consultant Contacted" section document the type of professional consultant contacted, the consultant's name, the date and time contacted, whether the consultant recommended an action/medical intervention and what action/medical intervention, if any, the consultant recommended.

7. If no medical intervention, illness, injury or death follows the occurrence, check "No" in the appropriate section. The supervisor should then review the MOR and comment if needed. Forward a signed and dated copy of the MOR to your DMH/DMR Area/Regional MAP Coordinator within seven (7) days. A list of DMH/DMR MAP Coordinators with addresses is provided on the reverse side of the MOR.

8. If a medical intervention, illness, injury or death follows the occurrence, check "Yes" in the appropriate section and indicate the type of event. The supervisor should then review the MOR and comment if needed. Notify DPH within 24 hours of the medication occurrence by telephone and/or fax (faxing is encouraged whenever possible). Forward a signed and dated copy of the MOR to your DMH/DMR Area/Regional MAP Coordinator within seven (7) days.

9. For the purpose of reporting, medical interventions include, but are not limited to, treatment in an emergency room, clinic or other health care facility; treatment by a health care provider; and/or, lab work or other tests. Since contact with the professional consultant is standard protocol for all medication occurrences, such consultation in and of itself would not constitute a medical intervention for the purposes of the reporting requirement.

10. The last section on the MOR lists the most common factors that contribute to medication occurrences. The site supervisor should review the factors involved in the occurrence and check all those that apply. If no contributing factors are involved, then "(g) none" should be checked. The supervisor may comment, as he/she deems necessary and appropriate. Additional space is available on the reverse side. The supervisor must enter his/her signature, title and date on the MOR.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Approved MOR Form **POLICY NO: 09-7**

DATE ISSUED: 1/1/05

SEE FORM ON THE FOLLOWING PAGE

Department of Public Health
Medication Administration Program
MEDICATION OCCURRENCE REPORT

Agency Name:_____ **Name:**_____
(Consumer/Client) Last First
Site Address:_____**Date/Time of Occurrence:**_____
Street **Site Telephone Number(____)**_____
_____**DPH Registration Number**_____
City/Town Zip Code

TYPE of OCCURRENCE:
(As per regulation, contact consultant.)

(1)_____Wrong Individual
(2)_____Wrong Medication (includes medication given without an order)
(3)_____Wrong Time (includes a "forgotten "dose)
(4)_____Wrong Dose
(5)_____Wrong Route

MEDICATION(S) INVOLVED:

	Name:	Dosage:	Frequency/Time:	Route:
As Ordered:				
As Given:				
As Ordered:				
As Given:				
As Ordered:				
As Given:				

CONSULTANT CONTACTED
_____Registered Nurse _____ Registered Pharmacist _____ Licensed Practitioner

Name of Consultant:_____**Date Contacted:**_____**Time Contacted:**_____
Last First
Recommended Action (Medical Intervention) ____Yes ____No
If Yes, check all those that apply:
(1)_____Lab Work or Other Tests (2)_____Physician Visit (3)_____Clinic Visit (4)_____Emergency Room Visit (5)_____Hospitalization
(6)_____Other (de*scribe*) _____

Did ☐ medical intervention, ☐ illness, ☐ injury or ☐ death follow the Occurrence?___Yes___No
If yes, notify DPH at (617) 983-6782 /FAX (617) 524-8062 within 24 hours. For ALL Occurrences, forward written reports to your DMH /DMR MAP Coordinator within 7 days. (See reverse side for addresses.)

Supervisory Review/Follow-up
Contributing Factors: Check all that apply. If none apply, check none (g) :

(a)___Failure to Accurately Record and/or Transcribe an Order
(b)___Failure to Properly Document Administration
(c)___Medication Administered by Non-Certified Staff (Includes instances where certification has expired or has been revoked)
(d)___Medication Had Been Discontinued
(e)___Improperly Labeled by Pharmacy
(f)___Medication not Available (Explain below)
(g)___None

_____

_____

_____**(If additional space is required, please use reverse side).**

Signature/Title:_____**Print Name:**_____**Date:**_____

0/30/96 **Occurrence Reporting is required by regulation at 105CMR 700.003(F)(1)(f).**
MAP9705.DOC **Consultant Contact is required by regulation at 105CMR 700.003(F)(1)(g).**

DMH MAP COORDINATORS	DMR MAP COORDINATORS
Area MAP Coordinator Western Mass Area Office Northampton State Hospital PO Box 389 Northampton, MA 01061	**Regional MAP Coordinator** Region I/Western Mass Commonwealth Community Services One Roundhouse Plaza Northampton, MA 01060
Area MAP Coordinator Central Mass Area Office Worcester State Hospital 305 Belmont Street Worcester, MA 01604	**Regional MAP Coordinator** Region II/Central Glavin Regional Center 214 Lake Street Shrewsbury, MA 01545
Area MAP Coordinator North East Area Office PO Box 387 Tewksbury, MA 01876-0387	**Regional MAP Coordinator** Region III/Northeast Hogan Berry Regional Center PO Box A Hathorne, MA 01937
Area MAP Coordinator Southeastern Area Office 3 Chambers Road P.O. Box 4007 Taunton, MA 02780	**Regional MAP Coordinator** Region V/Southeast DMR Region V 68 North Main Street Carver, MA 02330
Area MAP Coordinator Metro Suburban Area Office Quincy Mental Health Center 460 Quincy Ave. Quincy, MA 02169	**Regional MAP Coordinator** Region VI/Metro Area DMR Harbor 66 Canal Street Boston, MA 02114
Area MAP Coordinator Metro Boston Area Office 85 E. Newton Street Boston, MA 02118	

ADDITIONAL SPACE:_____

_____

_____

_____

_____

_____

_____

10

MEDICATION SECURITY AND RECORD KEEPING

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Administrative Policies & Procedures **POLICY NO: 10-1**

POLICY SOURCE: December 1994 MAP Advisory **DATE ISSUED: 12/94**

- All program sites shall have on file a master list of all certified staff members' certifications with dates of expiration and/or copies of staff certificates.

- All program sites must have on file up-to-date client-specific medication records

- Each site must also have a copy of the following:
    - It's agency's: list of approved consultants;
    - Policies and procedures related to access to consultants;
    - Policies and procedures for medical emergencies related to medication administration;
    - Approved medication occurrence reporting forms;
    - LOA policy;
    - Written policies for obtaining properly labeled medication containers;
    - Policies for identifying and educating individuals responsible for off-site medication administration;
    - Policy on access to the medication area; and
    - Medication-specific resource material containing, at a minimum, information on the specific medications being administered on site (e.g. Physician's Desk Reference).

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Medication Security **POLICY NO: 10-2**

POLICY SOURCE: December 1994 MAP Advisory **DATE ISSUED: 12/94**
1995 DMR Memorandum **DATE ISSUED: 9/12/95**

- Each program site must have a specific area dedicated to the storage of all Schedule II-VI prescription medications and OTC medications.

- Each program site must have procedures that limit the day-to-day access to this area to the individual authorized to administer medications during each shift and that limit possession of the key to the medication area to the authorized staff on that shift.

- Each program site must have procedures that provide that only one duplicate key to the medication area should exist and that the key should be in the possession of agency administrative staff.

- To limit the number of medication keys, the key should be stored in a locked area within the house accessible to designated staff only.

- The key should be replaced in the locked area after completion of the shift or personally given to the staff person assigned to administer medications on the incoming shift.

- The individual administering medications should keep the key on person during the assigned shift. If they need to leave the residence it should be placed in a secure place.

- Each individual program should have available a back-up key that is kept in a separate locked location. The knowledge of this location shall be restricted to the Program Director and Residential Supervisor.

- If at any time the medication key is lost or misplaced the appropriate administrative staff must be notified immediately.

- Each program site must utilize a bound medication count book for recording Schedule II-V medication administration and change-of-shift accounting of medications.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Schedules II - V **POLICY NO: 10-3**

POLICY SOURCE: December 1994 MAP Advisory **DATE ISSUED: 12/94**
1995 DMR Memorandum **DATE ISSUED: 9/12/95**

- Medication counts are to be conducted by two licensed and/or certified staff whenever control of the medication key is passed.

- A count must always occur at the start and end of each shift.

- DPH recognizes that there are some situations where two licensed and/or certified staff are not available at every change of shift. In those instances it is recommended that the single licensed/certified staff person coming on or off shift conduct a count and sign the medication count book. At the first opportunity for a two-person count, the count must be conducted.

- Under no circumstances should a two-person count be conducted less than once every twenty-four hours.

- All Schedule II - V medications must be doubled locked, i.e. locked box within a locked cabinet.

- In addition to contacting the Residential Supervisor and/or on call person, any discrepancy noted in the count should be reported to the Department of Public Health at (617) 983-6700 on the next business day after the discovery of the discrepancy.

- The count sheets must be maintained in a bound book within the medication administration area. (These books may be obtained from a commercial manufacturer or other bound books [i.e., composition books] may be used.)

- All Schedule II - V medications should be marked as such by the pharmacy.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Storage & Labeling of Medications **POLICY NO: 10-4**

DATE REVISED: 1/1/05

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1. Prescription and non-prescription (Over-the-Counter/ "OTC") medications for all individuals who are non self-medicating shall be labeled and stored in a locked container or area which is devoted strictly for medication storage, supplies, and records relevant to medication administration. (Policy books or other supplies are not to be stored in the area.)

2. Topical and internal medications are to be stored separately (i.e., different shelf or in separate containers).

3. Prescription medication requiring refrigeration must be stored in a locked container within the refrigerator on site, if necessary, or in a separate (locked) refrigerator dedicated to medication storage.

4. Only MAP Certified staff who are assigned the duty of administering medications during their assigned shift may have access to the medication storage areas.

5. Staff shall not repack or re-label any medications when medication is given at two different locations except as cited in MAP Policy 11-2.

6. If consumer receives medication at two different sites, a separate labeled prescription bottle or bubble pack will be obtained from the pharmacy for use at each separate site. The documentation for administration will remain the same at both sites. The residential program will remain responsible for notifying the off-site program of any medication changes and for supplying the necessary forms.

7. The program shall not store on-site more than a thirty-seven (37) day supply of prescription medication except when the prescription plan utilized by the client requires that they purchase an amount of medication in excess of thirty-seven (37) days at one time. Documentation of such a prescription plan requirement must be kept in the client's record at the program where the medications are stored.

8. A supply of OTC medication, in its original manufacturer's package and in an amount that is usual and customary, may be maintained at a program. (See Policy 6-9)

9. The program must maintain a record of when a prescription is filled and the quantity of medication dispensed by the pharmacy.

10. Any illegible, worn or missing labels should be referred to the pharmacy for replacement or issuance of new medication.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Disposal **POLICY NO: 10-5**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 4/97**

- All unused or discontinued medications must be destroyed on site or at the service provider's office. Medications are not permitted to be returned to the pharmacy for disposal.

- According to regulations at 105 CMR 700.003(f)(3)(c): "disposal occurs in the presence of at least two witnesses and in accordance with any policies at the Department of Public Health". DPH requires that disposal occur in the presence of two certified/licensed staff of which one of the two is supervisory staff.

- Whenever medications are destroyed, regardless of the quantity, the DPH approved medication disposal record must be used.

- Disposal must render the medications useless and must be in accordance with acceptable DPH disposal practices. Unless prohibited by local ordinance, acceptable practices include, but are not limited to, incineration at an approved site, flushing, melting the medication in boiling water, crushing the medication into fine dust and mixing with bleach.

- All medications returned to the program site, whether from LOA's, hospitalizations, Detox Centers, or other sources , must be destroyed as per DPH regulation. They cannot be reused by the program.

- Although the DPH approved disposal form only mentions Schedule II through V medications, it may be used for all medications.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Packaging of Prescription Medications **POLICY NO: 10-6**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 4/97**

- Department of Public Health policy requires that all Schedule II-V (Countable Substances) medications shall dispensed to, and maintained by the community program, in "blister" packs, "Bingo" cards, cassettes or other similar tamper-resistant packages. [105 CMR 700.005(A)]

- The current MAP inspection form utilized by DPH requires that: "all countable substances are received from pharmacy in tamper-resistant containers" (see Item #11) as defined above and that if found in violation, the program shall correct the violation "Immediately". Recognizing that an immediate correction timeline may present difficulties for vendors and sites, DPH is modifying its correction time frame to allow 30 days in which sites are expected to be in compliance.

- Multiple medications may not be packaged in one "window", "bubble", "cartridge", or other section of the above described tamper-resistant packages. Each type of medication should be in its own package and clearly labeled. Each individual dose should be in its own "window", "bubble", "cartridge" or other section. (105 CMR 700.005(A)

- Splitting, cutting or breaking of a tablet, pill or capsule is prohibited. All medication must be dispensed by the pharmacy in such a manner that it is ready for administration. For Schedules II-V, this means that the dosage ordered (e.g. a half tablet) should be packaged as such in the tamper-resistant packages described above.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Packaging by Pharmacist **POLICY NO: 10-7**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 4/97**

- A pharmacist can prepare medications in seven-day planners or cassettes. Please note that there are specific federal regulations that the pharmacist must follow for this type of packaging.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Drug Losses **POLICY NO: 10-8**

DATE REVISED: 1/1/05

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1. In the Commonwealth of Massachusetts, controlled substances include **all** prescription medications (Schedules II - VI). However, regulations require that only those prescription medications in Schedules II – V, (known as.Countables: e.g.narcotics, stimulants) be reconciled. (See Policy 10-2).

2. To comply with state regulations, drug losses for **all** prescription medications (Schedules II-VI) must be reported to DPH.

3. Because medication losses are **not** Medication Occurrences, they are not to be called into the DPH Medication Occurrence Hotline, nor should a Medication Occurrence Report (MOR) be filed. Rather, medication losses must be reported to the Drug Control Program (DCP) at DPH by the first business day after discovery [105 CMR 700.003(F)(1)(E)]. A *Drug Incident Report Form*, available on the DPH website under DCP, must be completed and faxed to the DCP (*see Policy 16-1 for DCP contact information; see Policy 16-3 for DPH website information*).

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Disposal Form **POLICY NO: 10-9**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 4/97**

SEE FORM ON THE FOLLOWING PAGE

CONTROLLED SUBSTANCE DISPOSAL RECORD

Agency ______________________ Program __________________ DPH registration # ________________

Item # ____________ Date last filled __________

Name ______________________ Date _______________

Medication/strength ________________________________

RX# __________________ Pharmacy ________________

Amount Disposed ____________ Reason _______________

____

Control. Substance Book # (countables) _____ Page # ______

Signatures: 1. Staff________________________________

2. Supervisor____________________________

Item # ____________ Date last filled __________

Name ______________________ Date _______________

Medication/strength ________________________________

RX# __________________ Pharmacy ________________

Amount Disposed ____________ Reason _______________

____

Control. Substance Book # (countables) _____ Page # ______

Signatures: 1. Staff________________________________

2. Supervisor____________________________

Item # ____________ Date last filled __________

Name ______________________ Date _______________

Medication/strength ________________________________

RX# __________________ Pharmacy ________________

Amount Disposed ____________ Reason _______________

____

Control. Substance Book # (countables) _____ Page # ______

Signatures: 1. Staff________________________________

2. Supervisor____________________________

Item # ____________ Date last filled __________

Name ______________________ Date _______________

Medication/strength ________________________________

RX# __________________ Pharmacy ________________

Amount Disposed ____________ Reason _______________

____

Control. Substance Book # (countables) _____ Page # ______

Signatures: 1. Staff________________________________

2. Supervisor____________________________

Item # ____________ Date last filled __________

Name ______________________ Date _______________

Medication/strength ________________________________

RX# __________________ Pharmacy ________________

Amount Disposed ____________ Reason _______________

____

Control. Substance Book # (countables) _____ Page # ______

Signatures: 1. Staff________________________________

2. Supervisor____________________________

Item # ____________ Date last filled __________

Name ______________________ Date _______________

Medication/strength ________________________________

RX# __________________ Pharmacy ________________

Amount Disposed ____________ Reason _______________

____

Control. Substance Book # (countables) _____ Page # ______

Signatures: 1. Staff________________________________

2. Supervisor____________________________

Destruction of all prescription medications in Schedules ll – V that are either outdated, spoiled or have not been administered due to a change in the prescription or a stop order shall be documented on the DPH approved disposal record. According to regulations at 105CMR 700.003(f)(3): "disposal occurs in the presence of at least two witnesses and in accordance with any policies at the Department of Public Health". DPH policy requires disposal to occur in the presence of two certified or licensed staff of which one of the two is supervisory staff. Failure to maintain complete and accurate records of drug destruction could result in revocation of your Controlled Substance Registration. Disposal must render the medication useless and must be in accordance with acceptable DPH disposal practices. Unless prohibited by local ordinance, acceptable practices include, but are not limited to, incineration at an approved site, flushing, melting the medication in boiling water, crushing the medication into fine dust and mixing with bleach. Medications are not permitted to be returned to the pharmacy for destruction.

All medications returned to the program site, whether from LOA's, hospitalization, Detox Center, or other sources, must be destroyed as per DPH regulation. They cannot be reused by the program.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Pharmacy Errors **POLICY NO: 10-10**

DATE ISSUED: 1/1/05

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1. Known or potential pharmacy errors identified by staff should be reported to the Board of Registration in Pharmacy (*see Policy 16-1 for contact information*)

2. The reporting of known or potential pharmacy errors requires completion of a Board of Pharmacy Complaint Form. This form may be found at: **www.mass.gov/dpl/boards/ph/forms.htm** or obtained directly from the Board of Pharmacy

3. If you have any questions about the reporting of pharmacy errors, please contact the Board of Pharmacy directly. **(See Policy 16-1.)**

11

LEAVES OF ABSENCE

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Leaves of Absence Policy (LOA) **POLICY NO: 11-1**

POLICY SOURCE: December 1994 MAP Advisory **DATE ISSUED: 12/94**
April 1997 MAP Advisory **DATE ISSUED: 4/97**
1997 DMH Memorandum **DATE ISSUED: 8/14/97**

Leaves of Absence (LOA)

Leaves of absence often require that a client receive only a portion of the originally dispensed medication. While the re-packaging of client medications is not encouraged, there are certain circumstances where it is permissible. The DPH recommends that whenever possible a pharmacist should be responsible for repackaging or "split-packaging" prescription medications. Split-packaging is a service that most pharmacies provide. For example:

- If a client/consumer routinely requires medication administration at more than one location (e.g. at his/her day program and residence or at a relative's home on weekends) the pharmacist should be asked to split the medication into two tamper-resistant packages, one for the day program or home consumption and one for the residence (Note: the day program must have certified staff and possess a Controlled Substances Registration. For home visits, the responsible family member should receive some training on administration and potential side effects)

- If a client/consumer will be away from their residence for a period of up to 72 hours; will not be under the staff's direct supervision; and the pharmacist is unable to prepare the medications, certified and licensed may prepare the medications for the LOA. (See section 11-2 for "Preparation of Medications for LOA".)

- All routine absences of less than 72 hours and all extended absences of greater than 72 hours require preparation of the medications by a pharmacist.

- Under no other circumstances does DPH permit the packaging of medications by certified or licensed staff.

- Unless a client/consumer is learning to self-medicate and meets all of the criteria and requirements noted in section seven (7) of this manual, he/she is not permitted to package his/her own medication.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Preparation of Medications for LOA **POLICY NO: 11-2**
POLICY SOURCE: December 1994 MAP Advisory **DATE ISSUED: 12/23/94**
April 1997 MAP Advisory **DATE ISSUED: 4/97**

- Packaging in tamper-resistant containers is not necessary for LOA Schedules II -V medications, however, as with all medications, only the exact number of doses necessary for the LOA may be repackaged.

- Consumers are not permitted to package medications under the LOA Policy. According to the DPH Advisory dated 4/15/97, the LOA Policy may not be used to cover the pre-pouring of medications for the purpose of training consumers in self-medication. (See Learning to Self-Medicate, Section 07-2)

- Unused LOA medications cannot be returned to the program for reuse. Certified and/or licensed staff must dispose of these medications as per DPH regulation.

- Medications for all routine absences of less than 72 hours and all extended absences of greater than 72 hours must be prepared by a pharmacist.

- For unplanned absences of less than 72 hours, medications may be prepared by certified or licensed staff. Staff must follow the following procedure:
    1. Use an appropriate sized container so that the required information can be put directly on the container (ask your pharmacist for a supply of containers and blank labels without the pharmacy name and/or directions.)
    2. Whenever possible, use a tamper-resistant container.
    3. The amount of medication needed for the LOA should be determined and transferred from the original card or container directly into the LOA container.
    4. The LOA container should be marked with all the necessary information. This information should be taken directly from the original medication card or container and must include at least the following, in accordance with M.G.L. Chapter 94C, sec.22:
        - Client's/Consumer's name
        - Name and strength of medication
        - Directions for usage (clearly stated - including specific doses & dosing times)
        - Prescribing practitioner's name
        - Date of dispensing
        - Any necessary cautionary statements (e.g. Take with food.)
        - Amount of medication in the LOA container
        - A separate container must be used for each type of LOA medication.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Documentation of LOA **POLICY NO: 11-3**

POLICY SOURCE: December 1994 MAP Advisory	**DATE ISSUED: 12/23/94**
April 1997 MAP Advisory	**DATE ISSUED: 4/97**
1997 DMH Memorandum	**DATE ISSUED: 8/14/97**
1995 DMR Memorandum	**DATE ISSUED: 9/12/95**

- When LOA medication is sent with a client/consumer, it must be noted as "LOA" on the individual's medication and treatment sheet.

- Also, any Schedule II - V medications sent on the LOA must be accounted for in the medication count book.

- Any LOA medication brought back to the site by the client/consumer cannot be used. This medication must be destroyed and documented in the approved manner.

- The client/consumer and his/her responsible party must be provided with written instructions for the LOA medications and with copies of the medication information sheets. This should be noted in the client's/consumer' record.

- Included in the list of instructions is: who, what, where and how to call for technical assistance; preparation and other instructions; and special circumstances, if any, for omission of the medication.

- The above information is to be reviewed with all individuals who will be administering medication or if this is not possible, at least one of the individuals.

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12

REFILLING PRESCRIPTIONS

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Refilling Prescriptions Guidelines **POLICY NO: 12-1**

POLICY SOURCE: April 1997 MAP Advisory **DATE ISSUED: 04/97**

- In MAP, prescription(s) may be refilled up to one week before the medication(s) runs out. If the consumer/client has Medicaid or other insurance coverage, the provider will need to follow the agency or company's guidelines for the refilling of prescriptions.

13

HEALTH CARE PROVIDERS ORDERS

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Transcription of Health Care Provider's Orders **POLICY NO: 13-1**

POLICY SOURCE: Policy Manual **DATE ISSUED: 9/1/98**

The Medication Occurrence Reporting System has shown that failure to accurately record and/or transcribe an order is the second leading contributing factor in medication occurrences in MAP. The breakdown in this important procedure is the leading cause for repeated occurrences. An improperly transcribed order may remain uncorrected over a long period of time resulting in increased risk of failure to manage the consumer's medical condition(s) as well as increased risk of adverse side effects. Even if these effects of improper medicating are reversible, which they usually are, improperly transcribed orders pose a significant risk for serious outcomes. For this reason, the Departments are revising the present curriculum and concentrating more training time on transcription of Health Care Provider's orders. In addition, the following established guidelines must be followed when transcribing an order:

1. The certified or licensed staff person who transcribes the order(s) must place a check mark in red, green or other readily distinguished color next to the order being transcribed. (The color should be designated by the service provider and is to be consistent throughout their sites.). This must be done for each and every order transcribed.

2. When all orders have been transcribed from the health care provider's order form to the Medication and Treatment Sheet, the certified or licensed staff must write "Posted", the date, the time and their name on the order form in the color designated by the service provider.

3. A second certified or licensed staff must review the orders that were transcribed by the first staff person and write "Verified", the date, the time and their name on the physician order form in the color designated by the service provider. If a second staff person is not scheduled when the orders are transcribed, then the next certified or licensed person on duty must follow the verification procedure described above and must review and verify the orders making the appropriate notation on the order form. The certified or licensed staff person who transcribes the order initially may, if a second staff person is unavailable, administer the ordered medications before verification is completed. However, the next certified or licensed person on duty must verify the orders immediately upon arrival at the site <u>prior to administration of the medication(s)</u>.

4. All certified and licensed staff must compare any change in a medication order with the health care provider's order before administering the medication.

5. Any health care provider's order that is unclear or confusing must be called into the health care provider. The health care provider must explain the order to the staff before the order is transcribed and the medication is administered. In addition,

written clarification must be obtained from the health care provider within seventy-two hours of the telephone verification.

6. In addition to the above, service providers must have a procedure for assuring that the health care providers' orders are reviewed on a regular basis and consistent with all medications being administered.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Documentation of HCP Orders **POLICY NO: 13-2**

POLICY SOURCE: 1995 DMR Memorandum **DATE ISSUED: 9/12/95**

- All medication orders must be written on some type of health care provider's order form. Only a licensed practitioner registered with the state of Massachusetts to prescribe can order medication. Each order must specify the following:

  (a) Time and date ordered, including the year
  (b) Name of the drug
  (c) Dosage
  (d) Route of administration
  (e) Frequency and duration of administration
  (f) Physicians signature
  (g) Pre-test medication orders must specify the period of time of
  (h) Pre-test administration, i.e. - one hour before EEG

- All orders for medication shall be noted on a medication and treatment form and contain at least the following information:

  (a) Name and dosage of medication
  (b) The time(s) the medication should be administered
  (c) By what route the medication is given (oral, optic, rectal, etc.)
  (d) If the medication is ordered for a set number of days the start and stop dates should be noted
  (e) Any special instructions for administration should be listed

- Any change in the medication order shall be considered a new order and documented as such on a medication and treatment form.

- All medications whether prescription or non-prescription (Over the counter [OTC]) shall be treated equally, that is:

  (a) all medication needs a physician's order
  (b) all medication is documented on a medication treatment form

- At any time when there is a change in orders (new drug, dose change, time change, etc.) this should be communicated to all staff verbally and a progress note should be written in the consumer's chart. Pharmacy labels on the actual medication containers should be flagged by the approved method and the pharmacy contacted for a new label.

- Monthly orders (computer generated or hand written) should undergo a quality check, i.e.,

    (a) All orders should be compared to the previous month to ensure accuracy.
    (b) The medication and treatment form should also be compared with the health care provider's orders and the pharmacy labels. (Health care provider's orders, transcriptions and pharmacy labels must all agree or medication may not be administered until orders are clarified.).

- If, for any reason, the medication is not administered as ordered, the reason why it was not given must be recorded on the medication treatment form (No Blank Spaces Are Acceptable).

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Telephone Orders **POLICY NO: 13-3**

POLICY SOURCE: 1995 DMR Memorandum **DATE ISSUED: 9/12/95**
December 1994 MAP Advisory **DATE ISSUED: 12/23/94**

Medication changes by telephone are allowed. When a telephone medication change is called in, staff should document the change in the individual's medication and treatment record. In addition, the person responsible for administering the medication should note clearly and boldly on the medication package that there is a new order and that the client's record should be checked. A change in medication orders does not necessarily require that the existing medication be destroyed. There are situations in which the existing medication can be used, either in higher or lower dosage or frequency of administration. Staff should contact the prescriber or their consultant or pharmacy to confirm whether or not the existing medication can be used or must be destroyed.

There will be occasions when a health care provider will provide a telephone order to a residence. If this occurs it is again treated as a new order and must be transcribed as such. In this circumstance the health are provider, in most cases, will call the pharmacy to notify them of the change in order (new drug, dosage change, change of route, etc.).

Additional documentation will be necessary if this takes place:

- The individual who obtains the order via the telephone will be responsible for transcribing the order.
- The new medication must be obtained from the pharmacy at the earliest convenient time.
- A physician's telephone order form must be filled out which will contain the following information.
  - (a) Address of residence
  - (b) Name of consumer
  - (c) Name of physician ordering changes
  - (d) Date of order
  - (e) Date of discontinuance
  - (f) Actual order and/or other instructions
  - (g) Signature of individual obtaining the order
  - (h) Time order received

- After the order is obtained and all information is gathered the original form must be mailed out or faxed to the health care provider for his/her signature. (All telephone orders must be signed within 72 hours.)
- A copy should go to the pharmacist if necessary. If the physician has called the pharmacy with the order this may be discarded.
- A copy will remain in the consumer record until the original signed physician copy is obtained.

- Once the signed physician copy is returned the residence copy may be discarded.
- If at anytime there is a concern or question about the order or the process, the protocol for technical assistance should be initiated.
- The new order should also be documented in the consumers progress notes in addition to the staff log and/or communication book.
- A telephone order taken by direct care staff must be verified by a nurse before that nurse may administer the medication. As evidence, the nurse may use a pharmacy-labeled medication container/pack that complies with regulatory needs. This label is to be compared with the health care provider's order sheet for accuracy.
- The agency should also verify any and all telephone orders at the earliest convenient time in the interests of safety.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Exhausting Current Supply of Medication **POLICY NO: 13-4**

POLICY SOURCE: 1997 DMH Memorandum **DATE ISSUED: 04/25/97**

A program should attempt to secure a properly labeled medication container from the pharmacy when the prescribing practitioner orders a change in a current medication. However, at times, due to pharmacy requirements and cost interests, it is acceptable to exhaust the current supply of the medication in question despite a change in dosage (or a change in the time of administration) provided **all** of the following four (4) criteria apply:

1. The prescribing practitioner supplies a new written order to the program that indicates on the new, changed order that the existing supply of medication may be exhausted;

2. The pill, capsule, or other vehicle is in a form that allows for "easy administration" of the new. changed order. i.e. the new dosage is an even multiple (up or down) of the medication on hand. Cutting or splitting of medication is not permitted. For example. an order for two (2) 10 mg. capsules BID of a medication could easily be administered if there was an increase to three (3) 10 mg. capsules TID or a decrease to one (1) 10 mg BID. However, it would not be possible, nor allowable, to use the existing supply of medication in this example if the order changed to one (l) 5 mg. capsule BID since cutting or splitting of the 10 mg capsule would be required;

3. The container has a brightly colored sticker affixed to it to alert the person administering the medication to the new, changed order; and,

4. The medication administration sheet (a) shows a stop of the old dosage and/or change in the time of administration and (b) is re-started to reflect the new, changed order.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Health Care Provider's Orders via FAX **POLICY NO: 13-5**

POLICY SOURCE: Policy Manual **DATE ISSUED: 9/1/98**

- Faxed health care provider's orders are legal orders and, therefore, are acceptable by the Departments. In fact, the Departments strongly urge the use of fax orders in place of telephone orders.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Renewal of Health Care Provider's Orders **POLICY NO: 13-6**

POLICY SOURCE: Policy manual **DATE ISSUED: 9/1/98**

- With the exception of DMH's requirement for the renewal of orders for psychotropic medications on a monthly basis, health care provider's orders, including standing orders, are valid for one year.

14

SPECIALIZED TRAINING PROGRAM

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Training for Epinephrine Administration **POLICY NO: 14-1**

POLICY SOURCE: Policy Manual **DATE ISSUED: 9/1/98**

Specialized Training Program
Administration of Epinephrine via Auto-injector Device(s)

Direct care staff who have completed the Basic Medication Administration training, have current certification in CPR and First Aid, and are recommended by their program are eligible to participate in this training.

Training is consumer/client specific and may not be transferred from one consumer/client, site or program to another.

The training will consist of three parts:

- Didactic/Lecture: The DPH approved curriculum shall be used in a classroom setting for this part of the course. A brief written examination will be given at the completion of this session to test general knowledge regarding administration of epinephrine via auto-injector devices.
- Demonstration: This will be done within the classroom setting with the use of a manikin or an anatomically correct body part (leg). The trainer should demonstrate the procedure that the certified direct care staff will be trained to perform including the outlining of each step in the process from gathering the equipment to completion of the administration of epinephrine and required documentation.
- Re-demonstration: The certified direct care staff to be trained should then demonstrate the process to the trainer. **This must be done with 100% accuracy!** Demonstration of the technique by the certified direct care staff must be done as many times as is necessary to assure competency with the administration. The determination of competency in epinephrine administration is solely the decision of the trainer.

For certified direct care staff caring for more than one consumer/client requiring administration of epinephrine via auto-injector device(s), additional training will be required **specific to each consumer/client.**

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Documentation of Specialized Training **POLICY NO: 14-2**

POLICY SOURCE: Policy Manual **DATE ISSUED: 9/1/98**

The trainer must submit the following information to their area/regional MAP coordinator at the completion of the training:

- The names of individuals who have successfully completed the Specialized Training Program
- An application for Specialized Training in Epinephrine Administration completed by each participant
- All test materials including the written test results and skill checklist.

The MAP coordinator will then forward the information to the appropriate Central Office. The trainer will document in the consumer's/client's record which staff have been trained to administer epinephrine via auto-injector device(s).

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Retraining for Epinephrine Administration **POLICY NO: 14-3**

POLICY SOURCE: Policy Manual **DATE ISSUED: 9/1/98**

The trainer will provide retraining and review to certified staff who have received Specialized Training every six months. After the retraining and review sessions, staff with Specialized Training must repeat the return demonstration with 100% accuracy.

Successful completion of the return demonstration sessions will be documented by the trainer and maintained in the client's/consumer's record by the service provider.

Verification of the successful completion of the return demonstration shall be provided by the trainer on a DPH approved form to the specially trained staff who will submit the proof of successful completion to a tester at the time of Recertification.

For Recertification certified staff would complete only one application that will be inclusive of both the basic medication administration and for verification of the specialized training. Certified staff, therefore, would have only one expiration date for both basic certification and the specialized training.

Verification of all successful return demonstrations will be forwarded with the staff's application for recertification and recertification test results to the area/regional MAP coordinator who will forward this information to the appropriate Central Office.

As with basic certification, staff who have completed the Specialized Training Program may not administer epinephrine once their specialized training has expired.

Upon expiration of the specialized training, the staff person would have to retrain and retest before administering epinephrine.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Requirements for Trainers **POLICY NO: 14-4**

POLICY SOURCE: Policy Manual **DATE ISSUED: 9/1/98**

- All trainers must be approved trainers for the Basic Medication Administration Program.
- All trainers shall complete a Specialized Training Program Trainer's Session.
- All trainers must use the DPH approved specialized training manual. No deviation from the protocols and procedures set forth in the training manual is permitted. Any recommendations that a trainer may have regarding the training materials must be submitted for consideration to DMH/DMR before final approval by DPH.

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MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Medication Administration via Gastrostomy / Jejunostomy Tube **POLICY NO: 14-5**

DATE ISSUED: 7/1/03

Please see attached for required forms and instructions regarding the approved specialized training requirements for drugs administered by MAP Certified staff via gastrostomy or jejunostomy tube.

PROCESS FOR INITIATING G/J TUBE CURRICULUM FOR MAP CERTIFIED STAFF

1. Provider will register individual with G/J tube with DMR using registration form.

2. If the Provider wants to train MAP certified staff to administer medications via G/J tube, they must submit to DMR written documentation from a licensed health care provider (Physician, Nurse Practitioner, Registered Nurse) that it is appropriate to train MAP certified staff to administer medications via the G/J tube to this particular individual. Such determination must include an evaluation of the staffing pattern in the individual's residence. The G/J tube registration form mentioned in #1 above can be utilized for this purpose.

3. MAP certified staff who are to be trained to administer medications via G/J tube will be approved separately for each individual that that they work with who has been deemed appropriate for this practice.

4. Once it is determined that an individual with a G/J tube is a clinically appropriate candidate to have medications administered by MAP certified staff, any change in their health status would require that a licensed health care provider once again evaluate the individual to determine if it is still prudent for MAP certified staff to administer medications to the individual via G/J tube.

5. Specialized training in administration of medications via G/J tube must be done by an RN.

6. Any G/J tube curriculum utilized by a provider to train MAP certified staff in the administration of medications via a G/J tube must contain the following DPH approved essential components:
   a) General overview of how G/J tube medication administration relates to MAP.
   b) Purpose of G/J tubes
   c) Overview of various kinds of G/J tubes
   d) Overview of different methods of tube feedings (bolus, continuous, intermittent)
   e) Importance of clean technique
   f) Maintenance of G/J tube
   g) Positioning issues with G/J tubes as well as specific positioning instructions for each individual
   h) Overview of signs and symptoms of G/J tube problems including G/J tube becomes dislodged, G/J tube occludes, diarrhea, respiratory difficulty, vomiting, site is red or has drainage as well as an individual specific protocol to manage such problems.
   i) How to prepare different forms of medication for administration via G/J tube
   j) Safe management and storage of formula and equipment including protocol regarding length of time a specific formula may hang for a specific individual and reuse of equipment.

k) Individual specific training regarding all of the above including on-site, individual-specific demonstration
l) Use of standardized competency evaluation tool.
m) A complete set of written materials used to train staff must be maintained at the program.

7. Staff qualifications to become certified to administer medications to an individual with a G/J tube:

    a. Has current MAP certification in good standing as determined by the agency.
    b. Has current CPR and First Aid certification
    c. Has completed vital signs training with demonstrated competence on a regular basis.
    d. Has successfully completed individual specific training to administer medications via G/J tube done by an RN following accepted MAP procedures for the administration of medication.
    e. Has successfully completed a medication administration via G/J tube training with an RN and has successfully demonstrated competency in this skill. This demonstrated competency evaluation must be repeated at least every two years to coincide with MAP certification or if the health status of the individual changes in such a manner that the RN deems it is necessary.

8. MAP Certified staff who are G/J tube approved are not allowed to administer medications via G/J tube without a competency review by an RN if six or more months have elapsed since that staff person administered feedings or medications to that individual via a G/J tube**.** In State operated community programs this will be monitored by an RN as part of the MAP oversight review process.

9. MAP Certified staff responsible for a medication occurrence involving the administration of a medication via G/J tube would be required to have at least a verbal review of the occurrence with the licensed health care provider responsible for clinical oversight of the G/J tube in addition to reporting the MOR according to MAP policy.

10. Changes in medication orders would need to be reviewed according to the Provider's policy by the licensed health care provider responsible for clinical oversight of the G/J tube prior to allowing G/J tube approved staff to administer. Additional training would be provided as appropriate.

11. If there is no nurse assigned to the program, a licensed health care provider should evaluate the individual in regards to skin integrity, tube placement, new orders, etc. and document such findings in the individual's record. This should be done on a regular basis as determined by the health care provider but no less than once every three months.

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Massachusetts Department of Mental Retardation

Gastrostomy / Jejunostomy Registration Form

Date: _____
Region:_____ Area/Facility:_____ Class Org:_____
Provider Agency:_____
Site Address:_____DPH MAP Reg. #_____
Name of Individual with G/J Tube:_____
Date of Birth:_____ S.S. #:_____

Type of Tube: Gastrostomy____
Jejunostomy____

Date of Placement of G/J Tube (approximate if necessary):_____
Reason for Placement of G/J Tube:
_____ Dysphagia
_____ Chronic Aspiration
_____ Nutrition Concerns
_____ Hydration Concerns
_____ Other (Please Specify)_____
_____ Unknown

Does this person:
_____ Receive feedings via their G/J tube?
_____ Receive hydration via their G/J tube?
_____ Receive medications via G/J tube?
_____ Have medications administered via G/J tube by licensed person?
_____ Have medications administered via G/J tube by MAP certified staff?

I have evaluated this individual and have determined that it is appropriate at this time for MAP certified, non-licensed staff to be trained to administer medications via their:

(Initial one)
____ gastrostomy tube
____ jejunostomy tube

_____	_____	_____
Printed Name of RN, NP or Physician	**Signature of RN, NP or Physician**	**Date**

REQUIRED

COMPETENCY EVALUATION TOOL for GASTROSTOMY (G) or JEJUNOSTOMY (J) TUBE MEDICATION ADMINISTRATION

Staff Name:_____ **Name of Individual**_____

Date:_____

	Pass Fail or N/A	**Assessed by: (RN name)**	GENERAL KNOWLEDGE
1.			Knows that only licensed personnel (nurses) and MAP certified staff, who have successfully completed specialized G or J tube medication administration training may administer medications through the G or J-tube.
2.			Knows that another competency evaluation will need to be completed if a MAP certified staff person who has successfully completed specialized training in G or J tube medication administration does not administer medications via G/J tube to an individual for a period of time exceeding six months.
3.			Knows that all MAP regulations must be followed when administering medications via G or J tube.
4.			Knows what gastrostomy and jejunostomy tubes are and why this individual has one.
5.			Knows a brand of formula should never be changed without a doctor's order.
6.			Is aware that there are 3 different methods of tube feedings. (Bolus, Continuous, and Intermittent)
7.			Knows that a method of tube feeding, rate and time may not be changed without a doctor's order.
8.			Knows that individuals with tube feedings need to be weighed as directed by RN, NP or Physician.
9.			Knows why water flushes are needed.
10.			Knows that good hand washing and cleanliness of G/J-tube equipment is essential in safe administration of tube feedings and medications.
11.			Knows the importance of elevated position of individual during feedings, flushes, and medication administration.
12.			States what s/he would do if the feeding tube became dislodged or appears to have moved in or out within the first 8 weeks of original placement of the tube. (When tract not yet well established.)
13.			States what s/he would do if the tube became dislodged or appears to have moved in or out after the first 8 weeks of original placement of the tube. (When tract is well established.)
14.			Knows the importance of preventing the tube from being pulled.
15.			States what s/he would do if the individual vomits while feeding is being administered.
16.			States what s/he would do if the individual had breathing difficulty.
17.			States what s/he would do if the individual had diarrhea.
18.			Able to identify some the causes of vomiting or diarrhea.
19.			States what s/he would do if stoma site has redness, swelling or purulent drainage.
20.			States what s/he would do and look for if pump alarm says the tube is blocked or that there is an occlusion.

REQUIRED

	Pass Fail or N/A	Assessed by: (RN name)	PROCEDURE FOR MEDICATION ADMINISTRATION
1.			Follows all procedures for preparation of medications for administration according to MAP regulations and policies.
2.			Assembles necessary equipment and enough water for pre and post med flushes.
3.			Prepares medications according to MAP. Shakes suspensions vigorously before pouring, and crushes pills finely before mixing with water or other liquid.
4.			Informs individual what is being done.
5.			Checks G/J tube placement if part of individual's G/J tube protocol
6.			Positions individual in correct position.
7.			Clamps/pinches G/J tube before unplugging or disconnecting feeding.
8.			Places plug or hangs feeding bag tubing so that they remain free from contamination.
9.			Inserts the tip of syringe barrel (which has been separated from plunger) into the tube, while continuing to pinch off the tube.
10.			Pours 20cc or other instructed amount of water into syringe and allows it to flow into stomach/intestine. (For J-tube may have to replace plunger back into barrel and push in gently for each water flush and medication)
11.			Pinches off tube just prior to syringe being completely emptied.
12.			Pours medications into barrel of syringe with 5cc to 10cc of water in between each type of medication.
13.			Ends medication administration with 20cc (or instructed amount) water flush
14.			Reinserts plug or resumes feeding.
15.			Documents administration according to MAP regulations and policies.

Based on this Competency Evaluation Tool, I, _____
Name of RN

Have determined that _____ is competent to administer
Name of Staff Person

Medications via G/J tube to: _____.
Name of Individual

_____ _____ _____
Signature of RN *Date* *Phone Number*

_____ _____
Staff Person Signature *Date*

REQUIRED

COMPETENCY EVALUATION TOOL for GASTROSTOMY (G) or JEJUNOSTOMY (J) TUBE WATER FLUSHES

Staff Name:_____ **Name of Individual**_____

Date:_____

	Pass Fail Or N/A	Assessed by: (RN Name)	PROCEDURE FOR WATER FLUSHES
1.			Checks physician's orders
2.			Gathers equipment
3.			Informs individual of what is being done
4.			Checks placement of tube if part of individual's G/J tube protocol
5.			Positions individual in correct position
6.			Washes hands
7.			Clamps/pinches G/J-tube before unplugging or disconnecting feeding.
8.			Places plug or hangs feeding bag tubing so that they remain free of contamination.
9.			While G/J-tube is still clamped/pinched separates barrel from plunger of syringe and places tip of syringe into tube
10.			Pours prescribed amount of water into barrel of syringe, unclamps the tube and allows water to slowly enter stomach /intestine by gravity. (For J-tube, may have to replace plunger back into barrel and push water in gently.)
11.			Clamps tube when syringe has just completely emptied.
12.			Inserts plug or reconnects tube to pump tubing.
13.			If indicated—rechecks setting on pump, turns pump on, and unclamps tube.
14.			Documents that flush has been given.

Based on this Competency Evaluation Tool, I, _____
Name of RN

have determined that _____ **is competent to administer**
Name of Staff Person

Water flushes via G/J tube to :_____**.**
Name of Individual

_____ _____ _____
Signature of RN *Date* *Phone Number*

_____ _____
Staff Person Signature *Date*

OPTIONAL

	Pass/ Fail or N/A	Assessed by: (RN Name)	**COMPETENCY EVALUATION TOOL for G OR J-TUBE BOLUS FEEDING** **Staff Name:_____ Name of Individual_____**
			PROCEDURE FOR BOLUS FEEDINGS
1.			Checks physician's orders
2.			Washes hands
3.			Gathers equipment—Correct amount of formula, water, 60cc catheter tip syringe (with barrel separated from plunger), and clean towel.
4.			Informs individual of what is being done
5.			Positions individual in correct position
6.			Pinches G-tube before unplugging tube and inserting tip of syringe into tube.
7.			Places plug so that it remains free of contamination.
8.			Pours prescribed amount of water into barrel of syringe, unpinches the tube and allows water to slowly enter stomach by gravity and pinches the tube just prior to syringe being completely emptied.
9.			Slowly pours formula into barrel of syringe and unpinched the tube to allow the formula to enter the stomach. Continuously refills the barrel before it completely empties, to prevent air from entering, until all of prescribed amount of formula has been poured into the syringe.
10.			Pinches G-tube just prior to syringe being completely emptied.
11.			Pours prescribed amount of water into syringe, unpinches tube, and allows water to enter stomach (to flush tube).
12.			Pinches G-tube when syringe has just completely emptied of water.
13.			Reinserts plug prior to unpinching tube.
14.			Documents that feeding has been given.
15.			Ensures that individual sits up for at least 60 minutes after feeding is complete.

Based on this Competency Assessment Tool I,_____ have
Name of RN

determined that _____ is competent to
Name of Staff Person

administer G/J tube bolus feedings to:_____
Name of Individual

_____ _____ _____
Signature of RN *Date* *Phone Number*

_____ _____
Signature of Staff Person ***Date***

OPTIONAL

COMPETENCY EVALUATION TOOL for G/J TUBE CONTINUOUS FEEDING and DISCONTINUATION of FEEDING

Individual Name:_____ Staff Name:_____

Date:_____

	Pass/ Fail or N/A	Assessed By: (RN Name)	PROCEDURE FOR CONTINUOUS FEEDINGS
1.			Checks physician's orders
2.			Gathers equipment and water for flush (20 cc of H2O if not otherwise specifically prescribed).
3.			Informs individual of what is being done
4.			Positions individual in correct position
5.			Washes hands
6.			Marks bag or bottle with current date and time
7.			Fills feeding bag with no more than 4 hours worth of formula unless otherwise directed by RN, NP or Physician..
8.			Primes tubing before connecting bag to pump.
9.			Clamps feeding bag tubing (of both old and new feeding bags) prior to removing old feeding bag from pump.
10.			Connects new feeding bag tubing to pump and sets desired rate on pump.
11.			Separates barrel from plunger of syringe.
12.			Clamps/pinches G/J-tube before unplugging or disconnecting tubing.
13.			While G/J tube is still clamped or pinched, places tip of syringe into G/J tube and pours 20cc (or other amount if so prescribed) water into barrel of syringe.
14.			Unclamps tube and allows water to slowly enter stomach/intestine by gravity. (For J-tube, may have to replace plunger back into barrel and push water in gently.)
15.			Clamps/pinches tube just prior to syringe being completely emptied.
16.			Connects tube to clean feeding bag tubing and unclamps tube.
17.			Rechecks setting on the pump and turns pump on
18.			Documents that feeding has been hung, the rate of feeding and how individual is tolerating procedure.
			PROCEDURE FOR DISCONTINUATION OF FEEDING
1.			Verifies by looking at physician's orders and MAR sheet that it is time to stop the feeding.
2.			Gathers equipment and water for flush (20 cc if not otherwise specifically prescribed.
3.			Informs individual what is being done.
4.			Turns off pump.

5.			Clamps or pinches G/J tube.
6.			Clamps or pinches G/J tube.
7.			Disconnects tube from feeding bag tubing. If feeding bag is to be used again, ensures tubing does not get contaminated.
8.			While G/J-tube is still clamped/pinched, separates barrel from plunger of syringe and places tip of syringe into tube.
9.			Pours 20 cc or other prescribed amount of water into syringe, unclamps tube and allows water to flow into stomach/intestine by gravity. (For J-tube, may have to replace plunger back into barrel and push in gently.)
10.			Clamps/pinches tube just prior to syringe being completely emptied.
11.			Clamps/pinches tube just prior to syringe being completely emptied.
12.			Unclamps tube.
13.			Checks G/J tube placement by measuring tube
14.			Documents as appropriate

Based on this Competency Assessment Tool I,_____
Name of RN

have determined that _____ is competent to administer
Name of Staff Person

continuous feedings via G/J tube and discontinue feedings via G/J tube to

_____.
Name of Individual

_____ _____ _____
Signature of RN *Date* *Phone Number*

_____ _____
Signature of Staff Person ***Date***

15

DPH CLINICAL PRACTICE REVIEW AND INSPECTION

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Clinical Practice Review & Inspection **POLICY NO: 15-1**

POLICY SOURCE: DPH Policy **DATE ISSUED: 10/27/97**

For the purpose of evaluating the Medication Administration Program for its safety and effectiveness, DPH conducts both inspections and clinical practice reviews. The outcomes of these evaluations facilitate the determination of the areas of strength and weakness. This in turn allows the Departments to develop policy; revise the curriculum, training and testing; and to address specific concerns raised by the evaluations.

The inspection is specific to the security and accountability of controlled substances (prescription medications). The inspection of a site usually takes one to two hours.

The clinical practice review is also specific. It addresses clinical issues and practices specific to medication administration. The clinical practice review takes two to three days to complete depending upon the size of the service provider. The first day consists of a visit to the service provider's main office during which policies and procedures are reviewed and the sites to be visited are determined. The following days consist of review of the medication administration practices and systems at individual sites. The stay at each site varies depending on its size and complexity of the consumers' care. The review is completed with an exit interview with the service provider during which the findings and a corrective plan of action are discussed.

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Clinical Review Process **POLICY NO: 15-2**

POLICY SOURCE: MAP Policy Manual **DATE ISSUED: 8/1/00**

The steps of the Department of Public Health's clinical review process for the Medication Administration Program may be summarized as follows:

1. Service providers are notified by DPH of the date and time scheduled for a clinical review.

2. The clinical review process is conducted at both the service provider's administrative office and at sites selected by DPH.

3. Following the clinical review, findings are reviewed with the service provider.

4. A copy of the clinical review findings is subsequently forwarded by DPH to the service provider and DMH or DMR.

5. The service provider is required to submit a plan of correction within 10 days to DPH and the appropriate licensing/certifying agency (i.e. DMH or DMR).

6. DMH or DMR, in consultation with DPH, conducts follow-up on the plan of correction.

Questions, concerns or problems regarding the clinical review process or findings should be directed to the DPH MAP Clinical Reviewer at (617) 983-6700 or addressed to the Drug Control Program, 305 South Street, Jamaica Plain, MA 02130.

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RESOURCES

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Contacts **POLICY NO: 16-1**

DATE ISSUED: 1/1/05

The following are central state agency and other contacts for MAP:

Department of Public Health (DPH):

Drug Control Program
Department of Public Health
305 South Street
Jamaica Plain, MA 02130

Phone: (617) 983-6700
Fax: (617) 524-8062

MOR Hotline: (617) 983-6782

Department of Mental Health (DMH):

Statewide MAP Director
Department of Mental Health
25 Staniford Street
Boston, MA 02114

Phone: (617) 626-8070
Fax: (617) 626-8077

Department of Mental Retardation (DMR):

Director of Health Services
Department of Mental Retardation
500 Harrison Ave.
Boston, MA 02118
Phone: (617) 624-7792
Fax: (617) 624-7577

Board of Registration in Pharmacy:

239 Causeway Street
Boston, MA 02114

Main Phone No: (617) 727-9953
Complaints: (617) 727-5970

State agency contact information is also available on agency websites through the Massachusetts portal at **www.mass.gov.**

American Red Cross:

786 Main St.
Melrose, MA 02176

(781) 979-4010
(800) 962-4337

www.bostonredcross.org/map

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: MAP Advisory Group **POLICY NO: 16-2**

DATE ISSUED: 1/1/05

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1. *Purpose*: The Medication Administration Program Advisory Group advises the Departments of Public Health, Mental Health and Mental Retardation on policy development for MAP.

2. *Membership*: The Advisory Group is comprised of representatives of state agencies, legislators, service providers, professional organizations, bargaining units and other interested parties. Membership is open to anyone with an interest in MAP.

3. *Meetings*: Advisory Group meetings provide a forum for exchange of information, discussion of policy issues, development of recommendations for program improvement and review of policies. Drafts of policies and other documents are routinely circulated among members, at meetings and through mailings, to solicit comments prior to finalization and general dissemination.

4. *Schedule of meetings*: The Advisory Group meets as needed to address emerging policy issues in MAP. Announcements of meetings are sent to all members. Attendance at meetings is voluntary and is not necessary to obtain information or provide comments on MAP. Requests for information and offers of feedback and input are always welcome.

5. *Contacts*: For further information on the Advisory Group or to request to be added to the membership list, please contact the DPH MAP Clinical Reviewer (see Policy 16-1 for contact information). For general questions or comments on MAP, please get in touch with any of the agency contacts (see Policy 16-1).

MEDICATION ADMINISTRATION PROGRAM
POLICY MANUAL

POLICY ISSUE: Publications **POLICY NO: 16-3**

DATE ISSUED: 1/1/05

The following MAP publications are available through the sources listed:

Publication		**Source**[1]
MAP Policy Manual		Area and Regional MAP Coordinators; State agency contacts; DPH/DCP website
MAP Training Manual		Area and Regional MAP Coordinators
Supervisors' Training Manual		Area and Regional MAP Coordinators
The Medication Administration Program: An Introduction		Area and Regional MAP Coordinators; DPH/DCP website
Technical Assistance Tool		Area and Regional MAP Coordinators

State agency websites may be accessed through the Massachusetts portal at **www.mass.gov.** (See Policy 16-1)